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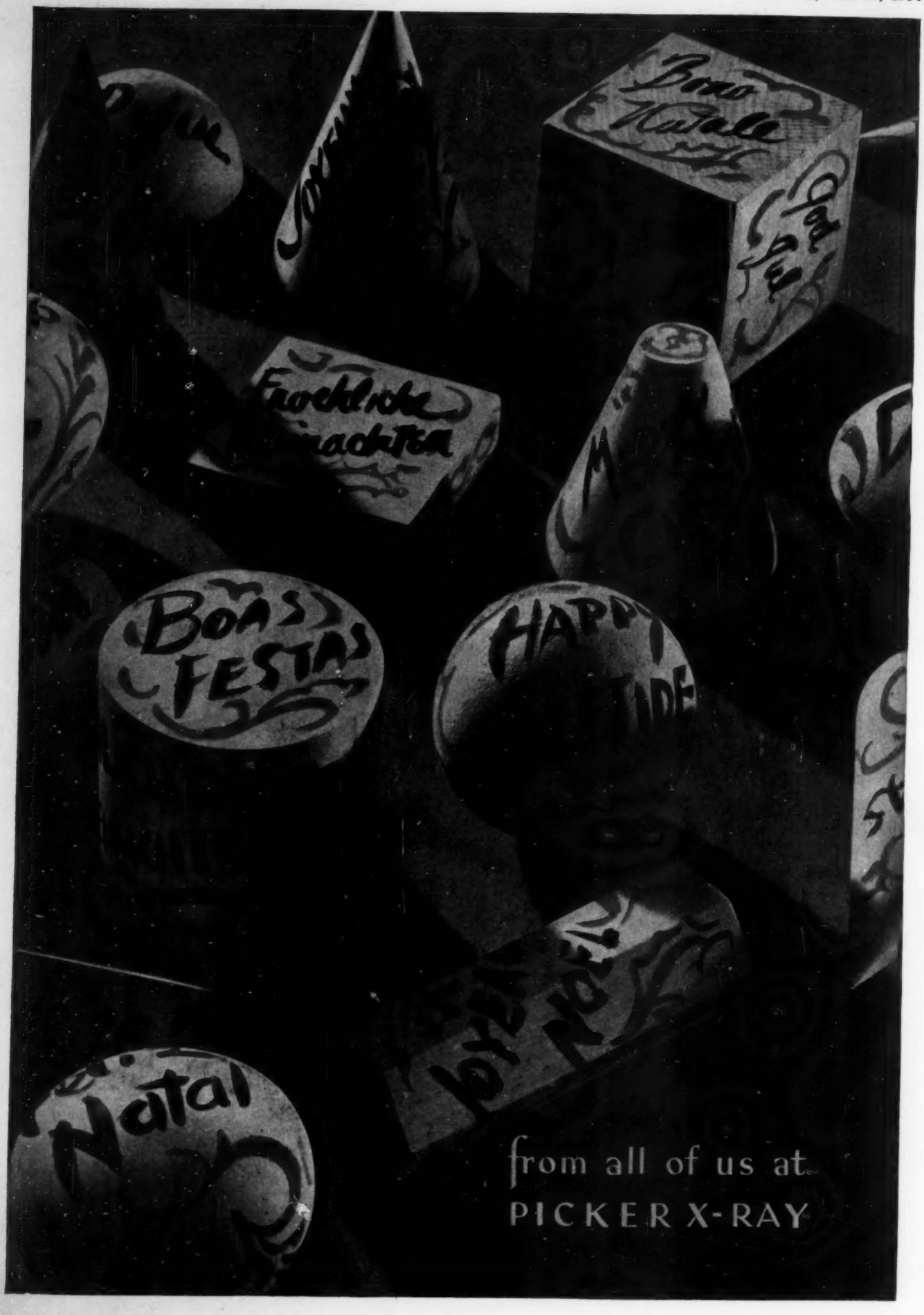
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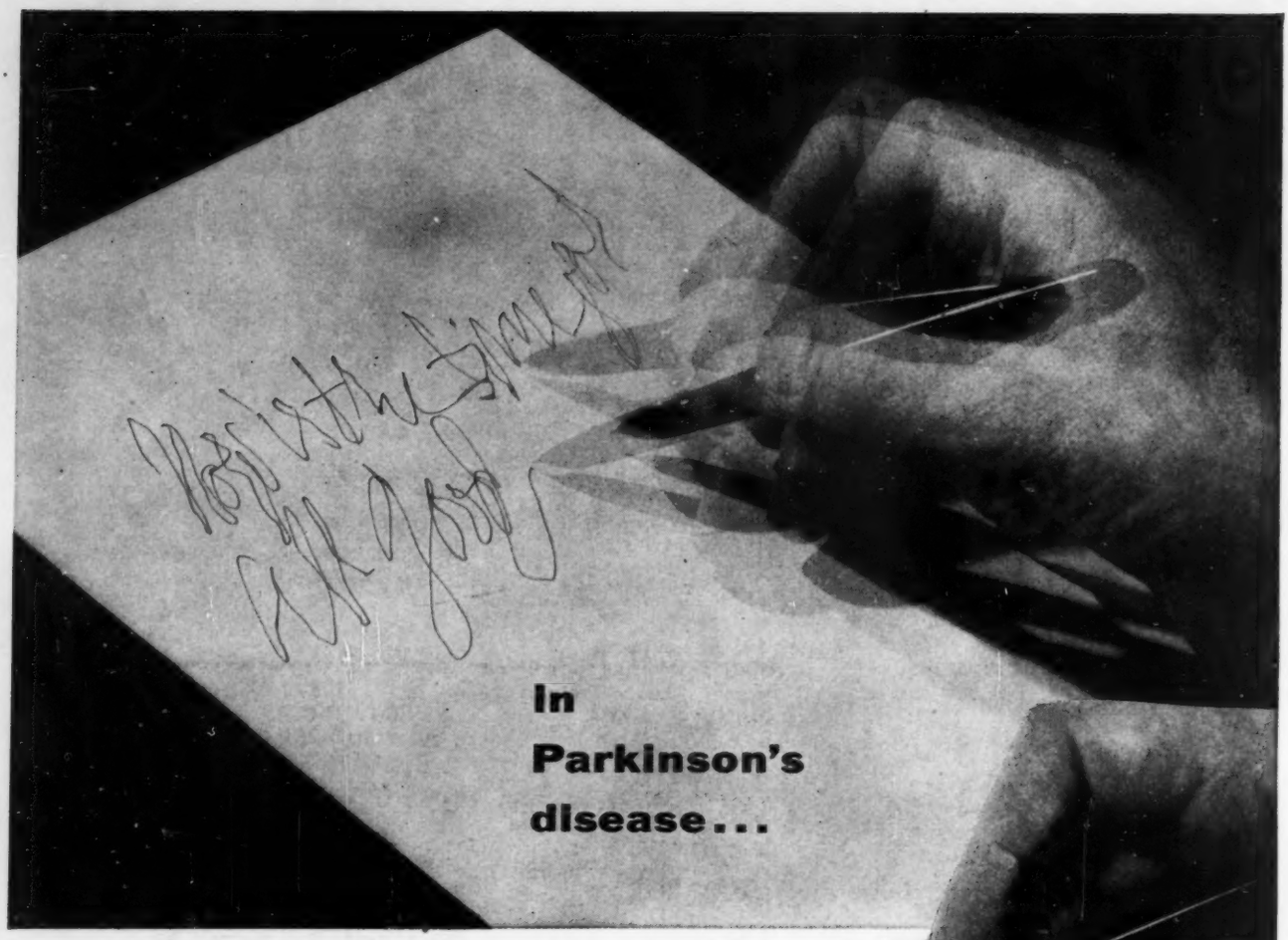

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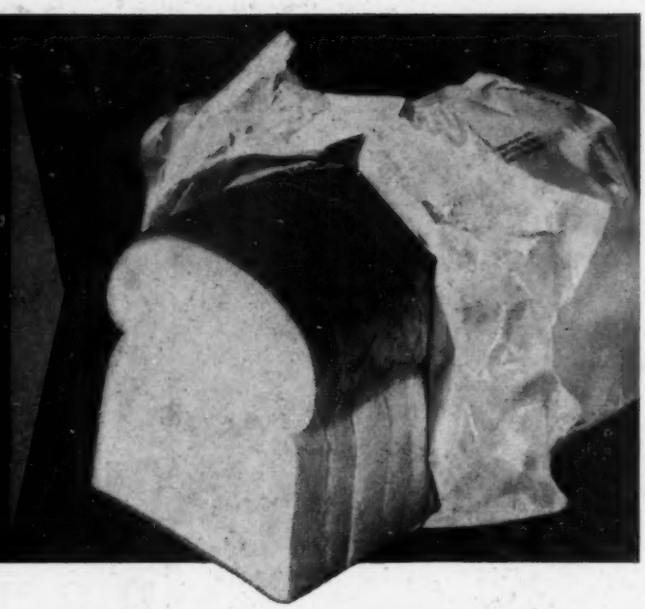

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1. The Committee on Dietetics of the Mayo Clinic: Mayo Clinic Diet Manual, ed. 2, Philadelphia, W. B. Saunders Company, 1954.
2. Sherman, H.C.: Chemistry of Food and Nutrition, ed. 8, New York, The Macmillan Co., 1952, pp. 212, 599.
3. Sherman, H.C.: The Nutritional Improvement of Life, New York, Columbia University Press, 1950, p. 133.

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WASHINGTON NEWS

RECOMMENDATIONS OF HEALTH OFFICERS' ASSOCIATION

The Association of State and Territorial Health Officers strongly recommends that Congress pass a bill designating the U. S. Public Health Service as a component part of the armed forces, with the same status and privileges accorded members and veterans of the Army, Navy, and Air Force. This was one of a series of resolutions and recommendations adopted by the association after the annual conference with the surgeon general of the PHS and the chief of the U. S. Children's Bureau. Representatives of state health departments and mental health and Hill-Burton hospital agencies also conferred with federal officials. The resolution noted that the PHS has been a commissioned service of the federal government for many years and that time served with the PHS is credited toward fulfilling physicians' draft obligations. However, this service does not confer veterans' rights and privileges, the resolution continued. The association said greatly increased activities of the PHS, such as new duties under civil defense, the staffing of the National Institutes of Health and 58 Indian hospitals, and promotion of international health through the World Health Organization, have created an emergency with respect to recruitment of qualified professional personnel. Action by Congress, the resolution added, would strengthen the ability of the PHS to maintain its existing personnel and recruit additional personnel to meet its expanded responsibilities.

In connection with international health, the association passed two other resolutions. One pointed out that, since many nations lack trained health personnel and since WHO provides a team approach of assisting these countries, Congress should be urged to appropriate enough funds to maintain the United States' proportionate share of WHO programs. The resolution further proposed that the U. S. delegation to the World Health Assembly in Mexico next May assure the nations of the world that "the United States is sincerely interested in supporting the program to aid in the control of communicable diseases on a world wide basis. . . ." The second resolution called for the PHS to establish a personnel pool for international health emergencies. It would consist of a list of competent, security-cleared public health personnel from state and local health departments and the PHS who would be available on short notice to participate on teams assigned to disaster areas for periods up to six months.

Considerable study was given to the problem of federal grants-in-aid for public health. A report of the association's Federal Relations Committee noted that "some states appear to carry a very high proportion of their public health costs, while others seem to lean on federal funds too heavily." States in the latter category "should correct this discrepancy within a reasonable period." It suggested that federal representatives meet with state budget directors or governors and find out why these states "fail to assume their responsibilities in public health." The committees recommended, with agreement of the association, that (1) the Department of Health, Education, and Welfare combine the four PHS health grants into a single consolidated grant to simplify administration, to reduce record-keeping and reports, and to increase effectiveness of health department activities, and (2) in distributing federal funds to states, a single allotment formula be used, based on population, extent of problem, and per capita income. Smaller states and territories and those with particular health problems would require special allocations with a specified minimum amount.

Dr. J. W. Roy Norton, North Carolina state health officer, was elected president of the association, succeeding Dr. Harold M. Erickson, Oregon health officer. Other officers are Dr. Daniel Bergsma, New Jersey commissioner of health, vice-president; Dr. Franklin D. Yoder, Wyoming director of public health, secretary-treasurer; and the following members of the executive committee: Dr. Erickson; Dr. T. F. Sellers, Georgia; Dr. Herman E. Hilleboe, New York; and Dr. Russell O. Saxvik, North Dakota.

THE DOCTOR DRAFT

Local draft boards are now processing physicians through the age of 37 for induction under the "Doctor-Draft" act, as against the previous age limit of 32. Selective Service headquarters said this change was necessary in order to fill the recent Defense Department quota of 1,275 physicians for induction in March. Selective Service informed boards: ". . . to meet this call it was necessary that priority 1, all ages; priority 2, without restriction as to months of service, and priority 3 born on or after Jan. 1, 1917, be used." Every effort, the agency added, is being made to process priority 3 physicians born after Aug. 30, 1922, to protect men of that priority who are older. Until the latest Defense Department call, the cutoff birth date had been Aug. 30, 1922. Selective Service also has placed a call for 459 dentists, to be available next March. They will be drawn from those in priority 1 of all ages, priority 2 without any restrictions on months of service, and priority 3 born on or after Jan. 1, 1910. Meanwhile, with the convening of the 84th Congress near, Senate and House armed services committees were awaiting word from the Defense Department on its plans for the doctor draft. It is scheduled to expire June 30, 1955, along with the regular draft. Defense officials already have announced intentions of asking for a four year continuation of the regular draft, but they have remained silent on the doctor draft.

CIO HEARINGS ON WELFARE FUNDS

The United States Chamber of Commerce, in a "preliminary appraisal" of the hearings of the Congress of Industrial Organizations on union welfare funds, concludes that union witnesses so far have been successful in diverting attention from the real issue. Health insurance is a major function of most of the funds. The chamber declares: "From the avowed objective to find ways of safeguarding the funds from mismanagement, the hearing early subordinated this fundamental purpose to a concerted attack on employers and the rigidly regu

From the Washington Office of the American Medical Association.

lated insurance business. Attention was centered on collateral issues, as one union representative after another leveled charges quite irrelevant to the basic issue of guarding against the defaults of personnel concerned with the internal management of the funds. Pervading the whole proceeding was this maneuver by union witnesses, featuring intemperate attacks upon fancied persecutors, always deemphasizing corruption within, and inflating the temptations outside the management of welfare funds.

"Thus the basic problem often went neglected, while witnesses went off on these excursions. How much damage was done by this reluctance to discuss the real issues because of its 'family scandal' aspect, can only be appraised after Committee findings and recommendations are in. There were some constructive suggestions offered and it is to be hoped that these will command primary attention.

"While the hearings were to be an over-all examination of welfare fund problems, many facets were not touched upon at all and others were given only passing mention. For instance, the collective bargaining problems connected with the establishment of employee benefit funds were not considered. Conditions surrounding the maladministration of present funds received little mention. Nor was any clear analysis of the merits or demerits of existing laws presented for consideration.

"However, the Chamber believes that good may still come out of the hearings. It believes that now that the witnesses have unburdened themselves of their charges against employers and others, they may feel more disposed to grapple with the announced objective-study of administration of union funds."

The first objective, according to the chamber, should be to "provide adequate safeguard against internal mismanagement [of the funds] . . . and to provide needed assurances to all beneficiaries of welfare funds."

RED CROSS GOAL OF 85 MILLION DOLLARS

In announcing that its 1955 campaign would have a goal of 30 million members and 85 million dollars, the American Red Cross emphasizes the importance of its medical programs. "This preparedness for what may come—particularly in our disaster, blood, first aid, and nursing services—requires continual strengthening of our programs," according to Red Cross Chairman E. Roland Harriman. "They cannot be put in moth balls, to be pulled out in case of a national emergency." For the next year the Red Cross blood program is budgeted for an estimated 14 million dollars, and 5 million is budgeted for disaster preparedness and relief. The first aid, water safety, and nursing programs will be allocated about 6 million dollars.

COURT UPHOLDS TUBERCULOSIS CLAIM

Admitting its "first impression" was that a workmen's compensation award for tuberculosis contracted on an overseas assignment "was predicated on a very far-fetched basis," the United States District Court, "after more intensive study and reflection," has upheld such a claim in Washington, D. C. The case arose out of a claim by a District of Columbia Red Cross employee who contracted the disease while on duty in Japan, where the tuberculosis incidence is five times that of the District of Columbia. The court decided that the claimant incurred a risk of contracting the disease that was five times the risk to which she would have been subject had she remained at home. Therefore, it concluded that the disease "was contracted not only during the employment but also out of the employment." The court also found support for its decision in a California case in which an award was sustained on similar facts. There the employee was sent by his employer from San Francisco to Chile, where he contracted typhoid. The disease is much more prevalent in that country than in the United States.

SUMMARY OF FOA'S HEALTH WORK

A report on nursing education in the Philippines highlights the most recent Foreign Operations Administration (FOA) summary of the agency's work in health fields. The report also mentioned health work in Israel, Formosa, Brazil, and other countries. The story on the Philippines covers curriculum for the schools, requirements for admission, tuition fees, examination practices, and administration procedures. The report is quoted at length to assist nations setting up similar programs. A highly successful malaria control program is under way in Libya, and an eye clinic has been established in answer to the plea of the desert tribesmen to "please do something for their eye diseases." There is a serious seasonal incidence of conjunctivitis in Libya. Israel, in its first monthly report, outlines an extensive program set up by the FOA public health division. Among the projects currently in operation are the opening of local health units, health education and sanitary demonstrations, an endemic disease control laboratory, mental hygiene courses for nursing schools, and the rehabilitation of the deaf and hard-of-hearing. Hospital administration programs are reported by a number of missions. In Formosa an entire month was devoted to study of the first class in hospital administration sponsored by the island's military hospitals, with the emphasis on developing "attitudes which will result in improvement plans in each hospital." Brazil reports a series of conferences to be held to lay the foundations for the administration of hospitals currently under construction as well as those soon to be started by the Amazon Valley Commission.

In addition to their regular activities, FOA missions are frequently called on to provide assistance during emergencies. FOA facilities and personnel in Haiti provided disaster relief after the severe storms, floods, and landslides brought about by hurricane "Hazel." Indo-China mission personnel have been handling the problems of evacuees and report that the resettlement of this large group of persons presents some of "the most fantastic and frustrating situations." However, the report adds, "this is not an unknown occurrence in any population and most certainly not completely unexpected to the health worker." The FOA publication, *Health Summary,* is published by the public health division of the agency. This month's issue makes a special appeal to the participating nations to submit monthly summaries with a view to "developing and improving methods whereby an exchange of technical information among health missions can be brought about."

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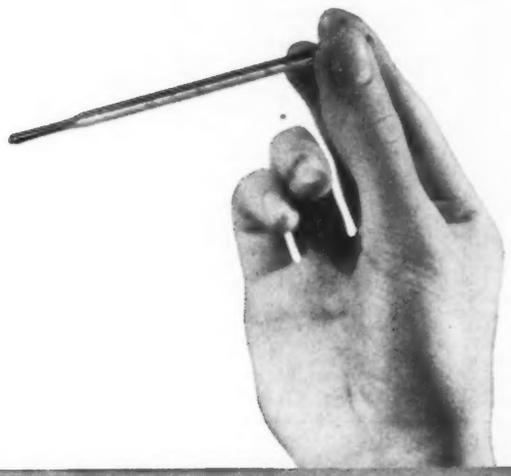

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LIST OF STATE MEDICAL ASSOCIATIONS

SOCIETY	PRESIDENT	EXECUTIVE OFFICER	ANNUAL MEETING
Alabama, Med. Assn. of the State of	Joseph M. Donald, Birmingham	D. L. Cannon, 537 Dexter Ave., Montgomery 4	Montgomery, April 21-23
Alaska Territorial Medical Assn.	Paul B. Haggland, Fairbanks	William P. Blanton, Box 2569, Juneau	
Arizona Medical Association	Oscar W. Thoeny, Phoenix	D. W. Melick, 541 Security Bldg., Phoenix	Tucson, May 4-7
Arkansas Medical Society	W. R. Brooksher, Fort Smith	Mr. Paul C. Schaefer, 215 Kelley Bldg., Ft. Smith	Hot Springs, May 29-June 1
California Medical Association	Arlo A. Morrison, Ventura	Mr. John Hunton, 450 Sutter St., San Francisco 8	San Francisco, May 1-5
Colorado State Medical Society	Samuel P. Newman, Denver	Mr. H. T. Sethman, 835 Republic Bldg., Denver 2	Denver, Sept. 20-23
Connecticut State Medical Society	Harold M. Marvin, New Haven	Creighton Barker, 160 St. Ronan St., New Haven	Bridgeport, April 26-28
Delaware, Medical Society of	Hewitt W. Smith, Harrington	N. L. Cannon, 1208 Delaware Ave., Wilmington	
District of Columbia, Med. Soc. of	Preston A. McLendon, Washington	Mr. T. Wiprud, 1718 M St., N.W., Washington 6	Washington, Oct. 10-12
Florida Medical Association	Duncan T. McEwan, Orlando	Samuel M. Day, P. O. Box 1018, Jacksonville 1	St. Petersburg, April 3-6
Georgia, Medical Association of	Peter B. Wright, Augusta	Mr. M. D. Krueger, 875 W. Peachtree St., Atlanta	Augusta, May 1-4
Hawaii Medical Association	Nils P. Larsen, Honolulu	Samuel L. Yee, 510 S. Beretania St., Honolulu	Honolulu, May 5-8
Idaho State Medical Association	A. Barclay Jr., Coeur d'Alene	Mr. Armand L. Bird, 364 Sonna Bldg., Boise	Sun Valley, June 19-22
Illinois State Medical Society	Arkell M. Vaughn, Chicago	Harold M. Camp, 224 S. Main St., Monmouth	Chicago, May 17-20
Indiana State Medical Association	W. L. Portteus, Franklin	Mr. James A. Waggener, 23 E. Ohio St., Indianapolis 4	French Lick, Oct. 16-19
Iowa State Medical Society	Gerald V. Caughlan, Council Bluffs	R. F. Birge, 529 36th St., Des Moines 12	Des Moines, April 24-27
Isthmian Canal Zone, Med. Assn. of	Irving J. Strumpf, Ancon	Avery P. King, Box "A," Balboa Heights	
Kansas Medical Society	Murray C. Eddy, Hays	J. A. Butin, 315 W. Fourth St., Topeka	Hutchinson, May 1-5
Kentucky State Medical Association	Clyde C. Sparks, Ashland	Mr. J. P. Sanford, 620 S. Third St., Louisville 2	Louisville, Sept. 27-29
Louisiana State Medical Society	Walter O. Moss, Lake Charles	C. Grenes Cole, 1430 Tulane Ave., New Orleans 12	New Orleans, May 2-4
Maine Medical Association	R. W. Belknap,* Damariscotta	Mr. W. Mayo Payson, 142 High St., Portland 3	Rockland, June 19-21
Maryland, Med. and Chir. Faculty of	Bender B. Kneisley, Hagerstown	Everett S. Diggs, 1211 Cathedral St., Baltimore	Baltimore, April 21-23
Massachusetts Medical Society	Curtis C. Tripp, New Bedford	Robert W. Buck, 22 The Fenway, Boston 15	Boston, May 17-19
Michigan State Medical Society	R. H. Baker, Battle Creek	L. F. Foster, 606 Townsend St., Box 539, Lansing 15	Grand Rapids, Sept. 26-30
Minnesota State Medical Association	Justus Ohage, St. Paul	Mr. R. R. Rosell, 496 Lowry Med. Arts Bldg., St. Paul 2	Minneapolis, May 23-25
Mississippi State Medical Association	Cummings H. McCall, Gulfport	Mr. R. B. Kennedy, 860 Milner Bldg., Jackson	Biloxi, May 10-12
Missouri State Medical Association	H. E. Petersen, St. Joseph	E. Royse Bohrer, 634 N. Grand Blvd., St. Louis 3	Kansas City, March 27-30
Montana Medical Association	J. J. Malee, Anaconda	Mr. L. R. Hegland, P. O. Box 1692, Billings	Bozeman, Sept. 15-18
Nebraska State Medical Association	Earl F. Leininger, McCook	R. B. Adams, 1315 Sharp Bldg., Lincoln 8	Omaha, May 16-19
Nevada State Medical Association	Dwight L. Hood, Reno	W. A. O'Brien III, 505 Chestnut St., Reno	Las Vegas, 1954
New Hampshire Medical Society	Raymond H. Marcotte, Nashua	W. H. Butterfield, 18 School St., Concord	Bretton Wds, Sept. 29-Oct. 1
New Jersey, Medical Society of	Elton W. Lance, Rahway	M. H. Greifinger, 315 W. State St., Trenton 8	Atlantic City, April 17-20
New Mexico Medical Society	John F. Conway, Clovis	Mr. R. R. Marshall, 221 W. Central Ave., Albuquerque	Albuquerque, May 4-6
New York, Med. Soc. of the State of	Dan Mellen, Rome	W. P. Anderton, 386 Fourth Ave., New York 16	Buffalo, May 9-13
N. Carolina, Med. Soc. of the State of	Zack D. Owens, Elizabeth City	Mr. James T. Barnes, 203 Capitol Club Bldg., Raleigh	Pinehurst, May 2-4
North Dakota State Medical Assn.	P. H. Woutat, Grand Forks	Mr. Lyle Limond, Box 1198, Bismarck	
Ohio State Medical Association	Merrill D. Prugh, Dayton	Mr. C. S. Nelson, 79 East State St., Columbus 15	Cincinnati, April 19-21
Oklahoma State Medical Association	Bruce R. Hinson, Enid	Mr. R. H. Graham, 1227 Classen Dr., Oklahoma City 3	Tulsa, May 8-11
Oregon State Medical Society	A. O. Pitman, Hillsboro	R. R. Carter, 1115 S.W. Taylor St., Portland 5	Portland, Sept. 28-Oct. 1
Pennsylvania, Med. Soc. of State of	Dudley P. Walker, Bethlehem	H. B. Gardner, 230 State St., Harrisburg	Pittsburgh, Sept. 18-23
Puerto Rico Medical Association	F. Hernandez-Morales, Santurce	L. R. Guzmán-López, Box 9111, Santurce	
Rhode Island Medical Society	Henri E. Gauthier, Woonsocket	Thomas Perry Jr., 106 Francis St., Providence 3	Providence, May 4-5
South Carolina Medical Association	Thomas R. Gaines, Anderson	Mr. M. L. Meadors, 120 W. Cheves St., Florence	Charleston, May 10-12
South Dakota State Medical Assn.	A. W. Spiry, Mobridge	Mr. J. C. Foster, 1st Nat'l Bank Bldg., Sioux Falls	Mitchell, May 21-24
Tennessee State Medical Association	John R. Thompson, Jackson	Mr. Jack E. Ballentine, 706 Church St., Nashville 3	Chattanooga, April 10-13
Texas Medical Association	F. J. L. Blasingame, Wharton	Mr. C. L. Williston, 1801 N. Lamar Blvd., Austin	Fort Worth, April 24-27
Utah State Medical Association	Charles Ruggeri Jr., Salt Lake City	Mr. H. Bowman, 42 S. Fifth East St., Salt Lake City 2	Salt Lake City, Sept. 8-10
Vermont State Medical Society	Howard J. Farmer, St. Johnsbury	James P. Hammond, 337 South St., Bennington	Bret. Wds., Sept. 29-Oct. 1
Virginia, Medical Society of	Carrington Williams, Richmond	Mr. R. I. Howard, 1105 W. Franklin St., Richmond 20	Richmond, Oct. 16-19
Washington State Medical Assn.	M. Shelby Jared, Seattle	Frederick A. Tucker, 1309 Seventh Ave., Seattle 1	Seattle, Sept. 11-14
West Virginia State Medical Assn.	Russel Kessel, Charleston	Mr. Charles Lively, Box 1031, Charleston 24	W. Sulph. Spgs., Aug. 18-20
Wisconsin, State Medical Society of	A. J. McCarey, Green Bay	Mr. C. H. Crownhart, 704 E. Gorham St., Madison 3	Milwaukee, May 3-5
Wyoming State Medical Society	Bernard J. Sullivan, Laramie	Mr. Arthur Abbey, Box 2036, Cheyenne	Laramie, June 5-7

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AFTER 16 YEARS... THE SAME CONCLUSION

"Approximately 39 to 47 per cent of resistant cases are reinfections from the sexual partner."[1]

In 1938 Karnaky[1] published a study of 150 women with recurring Trichomonas vaginalis infestations. No less than 38 of the husbands were also infected with the organisms which were recovered from the urethra, the prostate, or under the prepuce. A review of the literature at that time led Karnaky to estimate that "approximately 39 to 47 per cent of resistant cases are reinfections from the sexual partner."

In the June 26, 1954 issue of *The Journal of the American Medical Association,* Karnaky discusses the incidence of reinfection with Trichomonas vaginalis, and after evaluation of over a 1,000 cases, reiterates: "The real focus has been the male generative organ."[2]

In a recent study by Whittington,[3] the incidence of male infestation was 27 per cent. Trichomonal vaginitis occurs in "30 to 40 per cent of unselected patients," according to Upton.[4] He, too, finds, "Reinfection is annoyingly frequent." Donald,[5] working in a special clinic for patients with vaginal discharges, reports that the largest group of those attending the clinic are patients with trichomonal vaginitis, and that the relapse ratio is over 22 per cent. The majority of infections were due to sexual intercourse.

As one of the therapeutic measures in the treatment of Trichomonas vaginalis infections, Karnaky[1,2] recommends the use of a protective covering for the male during coitus, and suggests that the prophylactic use of a condom be maintained for at least four months. Bernstine and Rakoff[6] also advise the use of a condom "until it is certain the infestation has been cleared up entirely...If both members harbor the organism, similar protection should also be employed for at least three months after both have been apparently cured."

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references:

1. Karnaky, K. J.: Urol. & Cutan. Rev. 42:812, Nov., 1938.
2. Idem: J.A.M.A. 155:876, June 26, 1954.
3. Whittington, M. J.: J. Obst. & Gynaec. Brit. Emp. 58:614, Aug., 1951.
4. Upton, J. R.: West. J. Surg. 60:222, May, 1952.
5. Donald, I.: Brit. M. J. 2:1223, Dec. 6, 1952.
6. Bernstine, J. B., and Rakoff, A. E.: Vaginal Infections, Infestations, and Discharges, New York, The Blakiston Company, Inc., 1953, pp. 256 ff.

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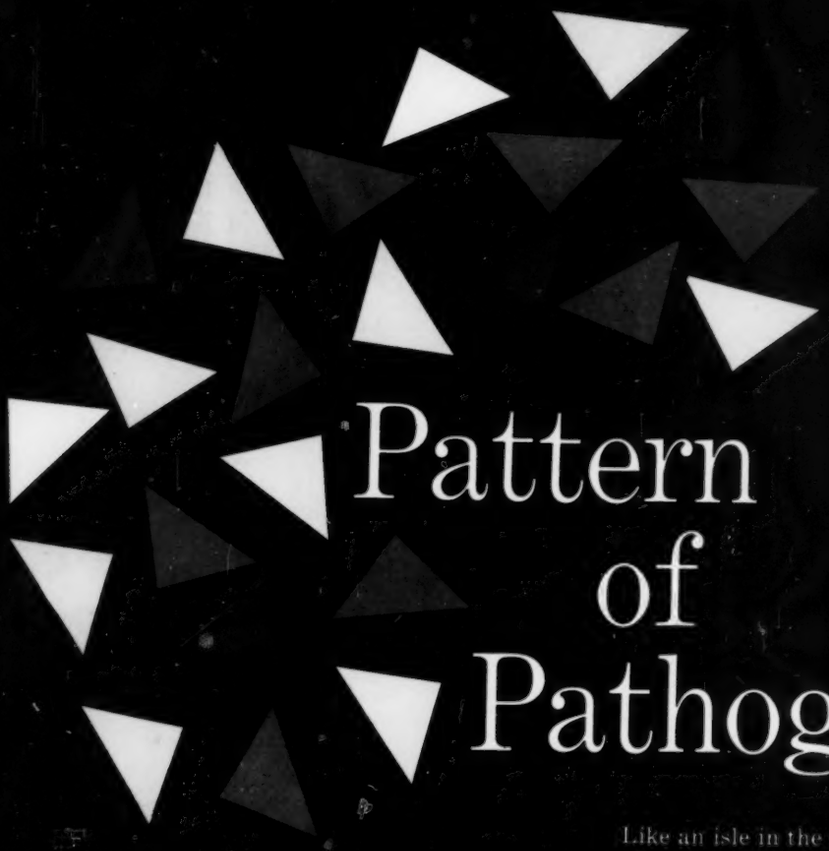
MEDICAL TV see page 24

Also this week: Intervertebral Disk Syndrome; Exocrine Function of the Pancreas



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Intervertebral Disk Syndrome

Myelogram shows a defect at the level of the involved intervertebral disk, caused by a herniated nucleus pulposus which is occupying part of the subarachnoid space. Myelography is desirable before surgery.

THE WEAK, LAME or painful back is among the most common of human ailments. When a patient complains of low back pain, disease or destruction of the intervertebral disk immediately comes to mind as the possible cause, though how often this is so is still a matter of debate. Opinions vary from enthusiastic adherents to the idea that intervertebral disk herniation is responsible for most low back pain to those who minimize the syndrome. According to a recent study by Ernest A. Brav (Letterman Army Hospital, San Francisco) analyzing 200 consecutive cases of backache, the probable incidence was determined to be 36.5 per cent. Besides being a cause of low back pain, it is also the commonest cause of "sciatica," and, as expected, "sciatica" is a common complaint with disk trouble. In R. K. Ghormley's (Mayo Clinic) 445 patients with suspected protruded intervertebral disks, 73 per cent had the sciatic syndrome.

The intervertebral disk is composed of 2 cartilaginous plates, a semi-gelatinous substance called the nucleus pulposus and a fibrous ring, the annulus fibrosus, surrounding it. The annulus fibrosus may rupture and the nucleus pulposus be protruded, or the cartilaginous plate may herniate and press against contiguous structures including the nerve roots. Chronic compression produces degenerative changes in the annulus fibrosus leading to the expulsion of the nucleus. The nucleus pulposus may be herniated laterally or in the midline. In either event there is narrowing of the intervertebral space with partial subluxation of the joint facets. Most commonly these changes occur in the lumbosacral spine and involve the fifth lumbar intervertebral disk.

Characteristics

When acute, the disk syndrome consists of a sudden pain in the lower back after forceful hyperextension. After a few days the pain subsides, but there are recurrences of "lumbago" now and then, for months or years, until pressure on a nerve root gives rise to "sciatica," with radiation of pain usually down the posterior or lateral aspect of the leg to the foot. In chronic cases there may be no history of an acute onset (or the occasion is forgotten), and radiation may be absent. Characteristically the pain is increased by extension and reduced by flexion of the lumbar spine; lateral flexion toward the side of the lesion causes pain, which is relieved by flexion to the opposite side. Bending, lifting, rising from a sitting position, coughing, sneezing or straining also increases the pain.

On examination the patient may be seen to walk with a limp; there are postural deformities with scoliosis — the curvature being away from the side of the lesion — and obliteration of normal lordosis (poker spine). Tenderness is usually noted over the lower back near the sacroiliac joint and often in the buttocks or along the sciatic nerve. The neighboring spinal muscles are in spasm, and lower spinal motions are restricted, especially hyperextension and lateral flexion toward the affected side. Shortening of one leg is found in 15 per cent of cases; there may be atrophy of the affected thigh or calf. Often there is pain on straight leg raising (Lasègue's sign) or on straightening the leg at the knee with the thigh flexed (Kernig's sign); the ankle reflex and the posterior tibial jerk are reduced or absent; sensation to pinprick over the lateral aspect of the distal thigh, calf, ankle and foot on the affected side is often decreased or absent; and there may be paresis of various leg muscles as evidenced by weakness of the extensor muscles of the foot.

Roentgen examination of the spine reveals subluxation of adjacent articular facets with constriction of the

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PICTURE CREDIT
PAGE 24: Courtesy of the Cleveland Museum of Public Health; from Dear Martin: Health show for half a million people. Today's Health, p. 34 (Sept.) 1954.

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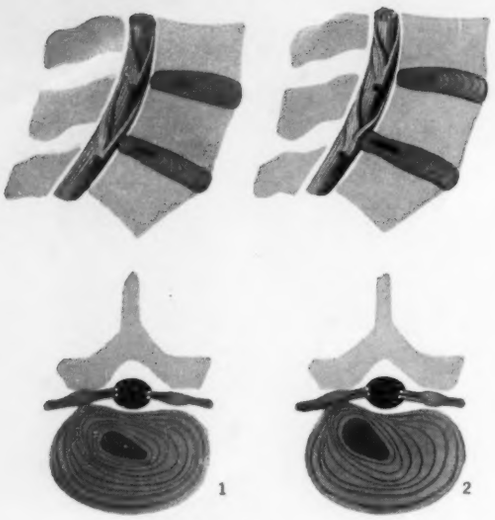
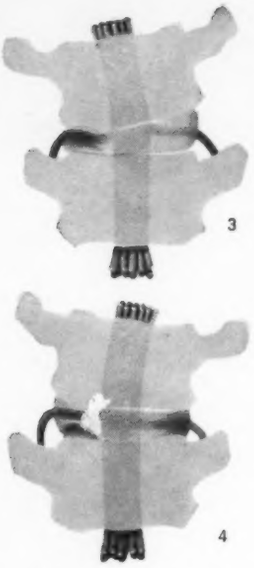
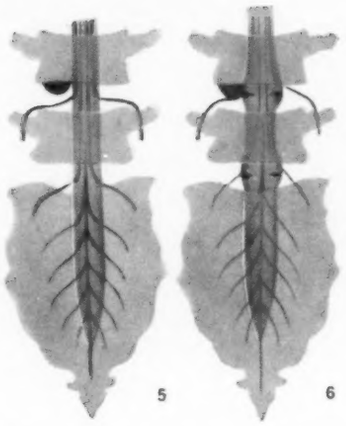


Relationships of the intervertebral disk, nucleus pulposus and nerve roots are shown in sagittal and cross section. Rupture of the annulus fibrosus with herniation of the nucleus pulposus or herniation of the cartilaginous plates causes the syndrome. With limited herniation the nerve roots are unaffected (1); when it is marked there is compression of the nerve roots resulting in the sciatic syndrome (2).



The degree of pain the patient experiences varies with the position of his spine. Lateral motion compresses the nerve root. With lateral flexion *toward* (3) the side of the herniated nucleus pulposus, the already narrowed space is further encroached upon, resulting in pressure on the nerve root and pain. With lateral flexion *away from* (4) the side of the lesion, the nerve root is released and pain is less.

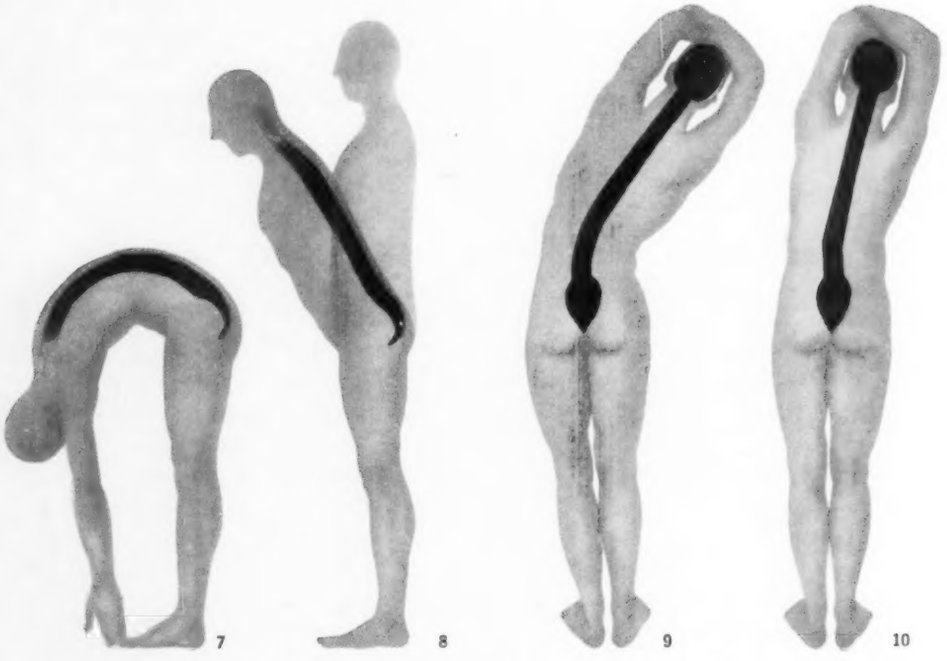


Compression of a nerve root and pain can result from straining for a bowel movement, sneezing, coughing, rising from a sitting position and carrying excessive weight — stresses that distend the arachnoid (arrows) and increase pressure on the nerve root. Relationships of the herniated disk, arachnoid and nerve root are shown before (5) and during (6) compression resulting from these stresses.

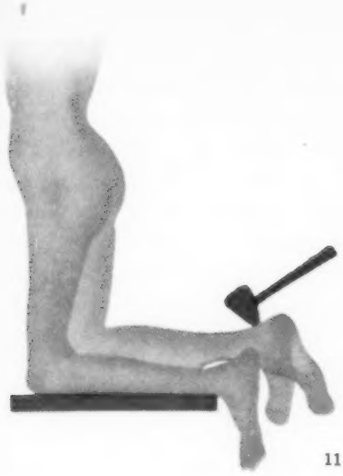
foramina; the intervertebral space is narrowed, and there is posterior displacement of the vertebra immediately above the involved disk. Myelography may reveal a defect at the level of the involved disk.

Treatment

Conservative management consists of rest, sedation, analgesics, heat and (when severe pain is no longer a limiting factor) an exercise program designed to develop the flexor muscles of the lumbosacral spine and to stretch the extensor muscles. When pain is severe, it is sometimes necessary to provide mechanical supports such as corsets, plaster casts, lumbosacral braces or strapping; these may be gradually discarded as the pain subsides. The prognosis with conservative therapy apparently is reasonably good. Ø. Ytrehus (Tonsberg, Norway) reported 256 patients with severe sciatica and positive Lasègue's sign treated in this fashion. On discharge from the hospital about one-half were free of symptoms, and most of the others were improved. Two to eight years later, when 86 per cent of



Postural deformities are common with the syndrome. Comparison of anterior flexion of the spine in the normal person (7) and in the patient (8) shows that in the intervertebral disk syndrome there are obliteration of normal lordosis (poker spine) and limitation of anterior flexion. Seen in comparison with the normal range of lateral flexion (9), movement toward the side of the lesion is limited by pain (10).



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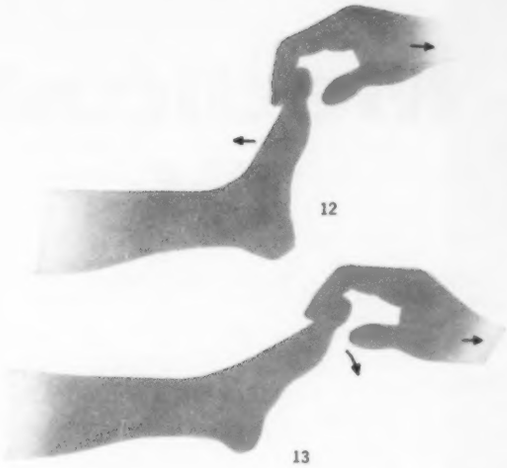

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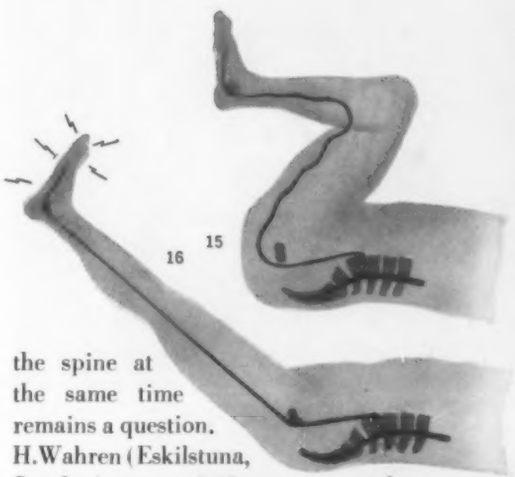

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Other neurologic signs than sensory changes are helpful in diagnosis. The normal reflexes may be affected, and there may also be motor weakness with concomitant trophic changes. The Achilles tendon reflex action is usually decreased or absent on the side of the lesion (11). Extensor muscles of the foot are weak on the affected side. Normal foot (12) can resist the examiner's pulling motion; affected foot (13) cannot. The posterior tibial jerk (14) is also diminished or absent on the side of the lesion. A helpful maneuver commonly used is straight leg raising, thus causing pain along the course of the sciatic nerve on the affected side (Lasègue's sign). In flexed position (15) there is no tension on the nerve and no pain; on straightening the leg (16) the nerve is stretched over the affected disk, resulting in pain.

the patients were re-evaluated, 34 per cent of these were without symptoms and actively employed, 37 per cent were symptomatic but working and 27 per cent were at least partly disabled. Thirty per cent had recurrences severe enough to require sick leave or hospitalization. G. Boysen (Oslo, Norway) has noted that relapse is rare after the age of 46. Another study of conservative therapy of intervertebral disk lesions by P. C. Colonna and Z. B. Friedenberg (Hospital of the University of Pennsylvania, Philadelphia) revealed that 29 per cent were pain-free at the end of the study, while 71 per cent had some residual pain. Of these, 45 per cent were completely disabled from time to time.

In recent years enthusiasm for surgical treatment of protruded intervertebral disk has been tempered considerably by the percentage of failures, which has been as high as 30 to 40 per cent. Such failures are due to a variety of causes, according to Samuel L. Turek (Northwestern University Medical School), among which are incorrect diagnosis, an overlooked disk in an adjacent interspace, an unsuspected contralateral disk, inadequate operative evacuation of the disk, scar formation and exostotic growth. He points out too that "the opportunity for re-operation rarely presents itself."

Surgical Intervention

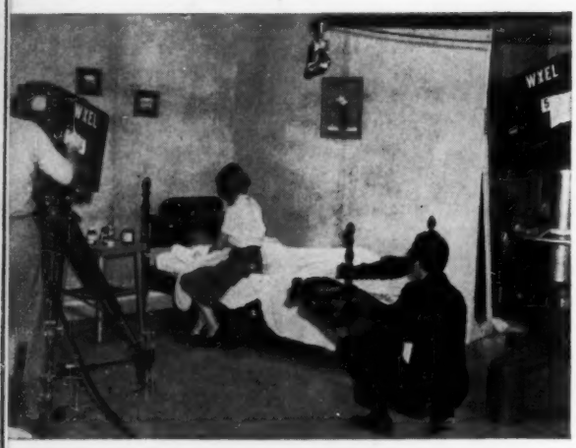
It is increasingly clear that surgery should be reserved for people incapacitated by repeated attacks of severe sciatic pain and in whom conservative measures have failed. Certainly surgery plays an important role whether used initially or following failure of conservative management. Approximately 70 per cent of patients are permanently relieved of acute sciatic pain and restored, at least in part, to satisfactory function following surgery. However, more than half of the patients continue to complain of aching or weakness of the back. Indeed, W. Waris (Helsinki, Finland) found in his series that the incidence of back pain was greater than before operation.

The best surgical technique for protruded intervertebral disk is still debated, and whether or not to fuse the spine at the same time remains a question. H. Wahren (Eskilstuna, Sweden) reported 60 per cent excellent or good results following spinal fusion in 71 patients incapacitated with low back pain due to degenerated disk without evidence of pressure on the nerve roots; in 40 per cent the results were fair or poor. In 1948 G. A. Caldwell and W. B. Sheppard (then of Ochsner Clinic, New Orleans) concluded, "There are no criteria for spinal fusion following removal of a protruded nucleus pulposus." J. S. Barr (Harvard Medical School) states that 74 per cent of his patients did well who had the combined operation as compared with 52 per cent after simple excision; and he believes that arthrodesis is useful "both as an adjunct to disk excision and as an independent procedure."

The patient with an aching back or "sciatica" wants relief from his pain, and the ability to stand and walk normally. Whether one favors initially conservative management, surgical intervention or a combination of methods, the outlook is good. END

Medical TV

...from your town



Dramatizations of medical misconceptions are combined with authoritative clinical discussions on "Prescription for Living," presented weekly over 7 Ohio television stations by the Academy of Medicine of Cleveland and the Cleveland Health Museum. In one typical program the Hampton family (above) deals in its customary, somewhat misguided fashion, with a common cold. Then a physician (bottom, left), Gerald S. Shibley of Cleveland, explains what is actually known regarding the common cold. An Academy committee selects physicians for their knowledge of subject and stage presence as well.

AS ANYONE CAN SEE from the forest of high-frequency antennas growing out of the roofs of America, television has engrossed a vast number of people, including the physician and his medical society. American medicine has been giving its interest and energies to television since at least 1946; in 1951 the Bureau of Health Education of the A.M.A. issued a *Television Handbook* in which W. W. Bauer, director of the Bureau, appraised television as a potentially "valuable tool" for health education. In April of that year there were barely 100 transmitting stations with no coast-to-coast network, and 10 million receivers. (By April 1954 there were 360 stations and some 30 million receivers!) Yet even in 1951 the Bureau supplied a dramatic film, "Dr. Webb of Horseshoe Bend," emphasizing the importance of the general practitioner and the problem of supplying physicians in rural areas. This program was bicycled around the country to provide substantial fare amidst what might charitably be called the mixed diet of television. The Bureau could furnish, in addition, a dozen scripts that local societies could use, and abundant directions and advice for getting up a local production.

In 3 years' time the idea was pursued with such enthusiasm that more than 50 cities in 26 states were showing (or getting ready to show) a medical society program — half of them weekly, some less often, but some even twice a week! The achievement is more amazing when it is realized that each was an independent production, complete in itself.

The highest quality is to be anticipated when the would-be producers see television as the medium of "peculiar characteristics" that it is. It has certain resemblances to the motion picture in that it is a *visual* medium — a fact so self-evident that it is routinely overlooked. But it is a visual medium of tiny scope, unless it can be rounded out with film, since the "stage" in television is ordinarily but a few paces wide. It is a one-shot phenomenon, irrevocable and irremediable, a fact that lends great immediacy and excitement but also, now and then, results in a catastrophe.

Seeing May Become Believing

What all this means practically is that the solemn reading of a paper makes no real use of television — it belongs to radio, if indeed it should be done at all. Television offers people a chance to *see*, and the ideal subject matter is that which ought to be *seen*. But what is seen should be informative and have its point to make — thus, it helps not at all to read a paper with grimaces and gesticulations that make the viewer tired. A patient's visible abnormality may have interest; actual sight of a patient who has recovered may have, with the clinical "story," a dramatic reality; 3 or 4 distinguished specialists who discuss a problem at length come over badly, but the same men *doing* something can be sensational. The front entrance to a great hospital is best seen on a postcard; on a television screen, where it is called an "establishing" shot (as in the movies), it betrays an infertility that has

become pandemic in this medium. There are a host of curious sights in clinical medicine — everyday matters for the physician but unknown to the public — that are easily shown, with their accompanying sounds, and can lend realism and assurance to what the lay person feels is obscure medical wizardry.

Live or Film

Should film be used? An all-film show can range widely, is safe from surprises and can be produced without pre-empting inconvenient hours for the physician-actor; but then it lacks immediacy. A no-film show is confined to events that take place (or can be rehashed) directly in front of the television camera. Such a show, while capturing the excitement of events-as-they-happen, may also produce gaffs that could be corrected or edited on film. Hence, many believe with J. R. Fox (University of Minnesota Health Service) that "film clips can help"; while Bruno F. W. Gebhard (director of the Cleveland Health Museum) says, "We don't care to use film." The fact that black-and-white movies will do nicely, so far — plus the proficiency of many physicians with a movie camera — can keep the costs moderate. But the proportion of film that has to be edited away, two-thirds at least, raises them again. If one can procure a fascinating variety of exhibits, film is probably second-best; if one has a $50 budget, film is out of the question.

Much can be learned from what local and state societies have already done: a weekly informal discussion of health subjects by local physicians assisted by a moderator as in Phoenix, Ariz.; panels and forums as in San Francisco and San Diego, Calif., Duluth, Minn., and Utica, N. Y.; weekly dramatic shows by the Hennepin County Medical Society, Minneapolis, and the Adams County Medical Society in Quincy, Ill.; question-and-answer programs with physicians only or with patients.

Vital to the success of any program is public awareness that it is going to appear; it has to be "promoted" through efforts of the state and county societies which are interested. Mr. Leo Brown (director of public relations for the A.M.A.) pointed out in the 1951 "Clinic on Television in Health Education" a variety of steps that can be taken to this end. Displays in schools, posters on bulletin boards in industry and easels in physicians' offices may announce the subject matter the program will cover and encourage people to watch it. Local newspapers eagerly seize upon what the physicians are doing as important news.

Even though some of the presentations are mainly conversational, they have all scored gratifying public responses. People are extremely interested in medicine. Mr. Brown has cited a survey showing that in the opinion of most newspaper editors medical topics are first on the list of people's interests. Television is a valuable means of satisfying these interests and, in the hands of the medical profession, it can do so effectively.

But medical television has raised some delicate questions too: How prominently should any physician appear? Where does "audience appeal" leave off and "self-exploitation" begin? A number of societies have adopted rules about anyone's appearing more than once in a season or making use of television that might be construed as improper by the usual ethical standards.

A survey of the cost factor has shown that a local society may spend anywhere from $60 to $800 for a show. Some of the societies manage to schedule regular programs at no direct cost to themselves at all. Gratifying cooperation of hospital officials, equipment manufacturers and the pharmaceutical industry seems to have been the rule. The time is usually donated; stations want medical television, when it is done well, because it enhances their prestige and affords an indisputable opportunity to serve "the public interest, convenience and necessity." END

Television stations are only too eager to cooperate with local medical groups on public service programs. King County Medical Society, Seattle, and University of Washington Medical School jointly offer a medical program (top) every other week on KING-TV's weekly "King's Community Service." John E. Stewart, Seattle orthopedist, allays mother's anxiety about baby's stance by comparing it with that of a boxer. Physicians frequently use their own patients on this program. On "Ask the Doctor" in Los Angeles (center), sponsored weekly by the California and Los Angeles County Medical Associations, physicians answer, ad-lib, written questions submitted by the audience. "Your Bones and How They Work" was discussed by Norbert J. Wegmann, Milwaukee surgeon, on "Your Family's Health" (bottom), sponsored by the Medical Society of Milwaukee County.

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Nausea and vomiting associated with vertigo, labyrinthitis, Menière's syndrome and radiation sickness may also be controlled with Bonamine.

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Seen & Heard

—Reports in the news

Paralysis of Newborn By Intrauterine Pressure

Zurich, Switzerland—The majority of newborn paralyses result from heightened intrauterine pressure and cannot be ascribed to the obstetrician, state H. Willi and G. Mürset (Women's Clinic, University of Zurich). Of 60 newborns with facial paralysis, delivery was spontaneous in 37, forceps were employed in 15, breech extraction was done in 4 and section in 4. Paralysis among those born spontaneously is attributed by Willi and Mürset to pressure of the maternal symphysis or promontory on the fetal facial nerve. In exceptional instances some other obstruction such as a myoma of the cervix may lead to facial paralysis.

Of 46 newborns with brachial plexus paralysis, breech presentation occurred in 33 (72 per cent), and in 13 cases the position was occiput posterior. Fourteen infants were delivered spontaneously, and 31 were extracted manually or by forceps. In 20 deliveries there was a deficiency of amniotic fluid, and in the same number premature rupture of the membranes.

Radial nerve paralysis was present in 25 newborns. Of these, 15 (60 per cent) delivered spontaneously. The second stage of labor was relatively long in this group (average 165 minutes), and in 16 cases there was little or no amniotic fluid. Seven newborns with radial nerve paralysis exhibited a pressure mark with subcutaneous fat necrosis on the outer surface of the upper arm in the area of the paralyzed radial nerve.

(Reported at the International Congress on Gynecology and Obstetrics, Geneva.)

Favorable Report on I^{131} In Hyperthyroidism

Chicago — A 6- to 80-month follow-up on 438 patients with hyperthyroidism treated with radioactive iodine is reported by Dwight E. Clark (Professor of Surgery, University of Chicago). The tally is so favorable, he reports, that I^{131} may be recom-

mended to replace surgery for Graves' disease. Of patients with hyperthyroidism 80.2 per cent became euthyroid, 19.1 per cent became hypothyroid and 0.7 per cent had recurrences. Included were patients with uncomplicated hyperthyroidism in older age groups; recurrent or persistent hyperthyroidism after thyroidectomy; hyperthyroidism with severe cardiovascular or other concurrent disease; and patients who failed to respond to antithyroid drugs, refused surgery or had severe exophthalmos.

(Reported at the Mississippi Valley Medical Society, Chicago.)

Extensive Surgery for Carcinoma of Cervix

Okayama, Japan — A type of hysterectomy far more extensive than the radical Wertheim's operation for cancer of the cervix is described by Yogi Hideo (University Medical School of Okayama). The procedure, termed the Okabayashi operation, is an abdominal hysterectomy with pelvic lymphadenectomy. The main features are:

- abdominal hysterectomy with removal of the vaginal fornices;
- systematic removal of the parametrial tissues as close as possible to the pelvic wall;
- performing the posterior procedures, such as isolation of the rectum and resection of the cardinal ligament and the uterosacral ligament, prior to the anterior procedures;
- systematic separation of the ureter in the vesical part and lateral part of the bladder;
- systematic and complete removal of pelvic lymph nodes.

(Reported at the International Congress on Gynecology and Obstetrics, Geneva.)

Complications of Leprosy Among Different Peoples

Bombay — When North Americans and Western Europeans acquire leprosy they are likely to develop malignant leproma, observes V. R. Khanolkar. Among natives of India and Africa, on the other hand, the more benign tuberculoid type of leprosy is much more common. The key to this difference does not lie in the factor of racial immunity acquired by centuries of exposure. Khanolkar points out that in certain groups in which the disease has been prevalent throughout known history, such as the Mongolian peoples and the Burmese, the more serious lepromatous type is also the more prevalent, as among Occidentals. The determining factors are not yet understood.

(Reported at the International Congress of Clinical Pathology, Washington, D. C.) END

In SPECTRUM Next Week

Tonsillectomy and Adenoidectomy — *Present-day views concerning the function of the tonsils and adenoids, their effects when diseased, and approaches to management.*

Treponemal Immobilization — *A report on a new test which may be a possible answer to the important problem that is raised by the "biologically false positive" serologic tests for syphilis.*

Doctors as Writers — *An illustrated story about physicians, past and present, who have made impressive contributions to world literature. The imposing list of physician-writers ranges from Rabelais and Keats to Maugham and Williams.*

Pfizer ANTIBIOTICS newsletter

Pinworm infestation yields to Terramycin — Oral Terramycin produced "cure" in 39 of 54 children with enterobiasis, report E. L. Kendig, Jr., and G. G. Arnold in *Antibiotics and Chemotherapy 4*:1111 (Oct.) 1954. Criterion was three negative smears 1, 2 and 3 weeks after treatment. Dosage: 5 mg./Kg. daily for 1 week. Children were treated as out-patients and treatment was prescribed for the entire family.

— Antibiotics Newsletter, Vol. IV, No. 18

Exocrine Function of the Pancreas

KNOWLEDGE of the exocrine function of the pancreas has made available tests for recognizing clinically important abnormalities of that organ. And this is significant, for the pancreas has yielded information about itself only with reluctance. Even when the pancreas is acutely inflamed, physical examination of the patient does not reveal the source of the trouble for, hidden posteriorly and centrally in the body, it resists palpation even if enlarged; and study by roentgenogram is mostly unrewarding. When diseased, its symptomatology is so varied that many other diseases seem more likely — such as gallbladder disease, coronary disease or even a perforated peptic ulcer.

Study of the content of the pancreatic juice secreted into the duodenum was facilitated by the use of the double lumen tube. Such a tube is introduced so that it has one opening in the duodenum and the other in the stomach for aspiration of stomach contents to prevent admixture. Information acquired in this way plus that previously obtained in animal experiments using duodenal fistulas gives the following picture.

Constituents

Pancreatic juice is a clear, colorless fluid consisting of water, electrolytes and enzymes. Specific stimuli to the pancreas govern the concentration of these contents. Thus cholinergic fibers of the vagus and splanchnic nerves stimulate the acinar cells of the pancreas to secrete a juice high in enzymes but of no great volume. Insulin hypoglycemia also exerts such an effect, presumably by acting on vagal centers. Pancreozymin, a hormone from the intestinal mucosa, reaches the pancreas via the blood stream and also evokes a high-enzyme, low-volume secretion. The intestinal tract itself secretes pancreozymin when soaps, peptones and starches are within it.

Another hormone, secretin, is the primary stimulant for copious, alkaline pancreatic juice with probably no enzymes present. Although the total anion content is about the same as that of blood plasma, bicarbonate and chloride vary in a reciprocal manner. When there is a maximal output of pancreatic juice, the highest concentration of bicarbonate is achieved and the pH may reach 8.3. Secretin originates in the duodenal and jejunal mucosa and is released when there is an acid pH in the upper part of the intestine. Peptones and fatty acids in the intestinal tract also excite the release of secretin so that achlorhydric persons do not suffer from pancreatic insufficiency.

Thus the character of the pancreatic juice depends on the relative amounts of secretin and pancreozymin in the blood stream and on the activity of the autonomic nervous system.

The enzymes finally synthesized by the acinar cells are proteolytic (trypsin, chymotrypsin and carboxypeptidase), glycogen and starch digestive (amylase) and neutral fat hydrolyzing (lipase). Blood amylase and lipase normally derive from absorption of a small part of the pancreatic output. Since blood contains an antitryptase, the presence of trypsin in blood is not detectable directly.

Other enzymes of lesser significance said to be present in the pancreatic juice include maltase, sucrase, lactase and alkaline phosphatase.

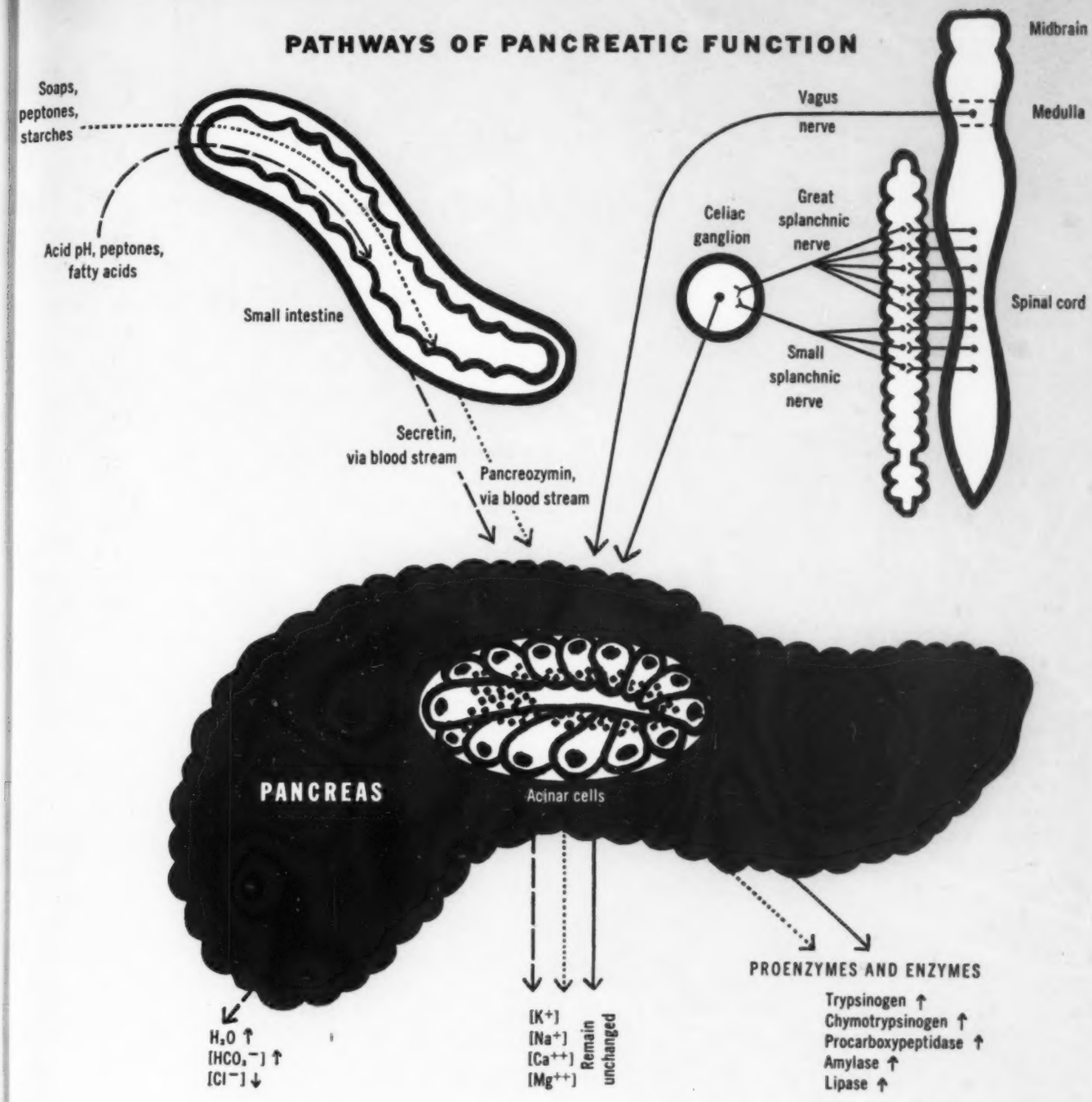
Methods now available for study of pancreatic function include: (1) the determination of amylase and lipase levels in the serum and — less satisfactory and therefore seldom examined — the quantity excreted in the urine; (2) study of volume, bicarbonate content and enzymes in the duodenal contents aspirated by a double lumen tube; and (3) examination of the feces for failure of digestion manifested by the excretion of undigested fat and later nitrogen. This failure occurs only when pancreatic disease is far advanced, with three-quarters or more of the pancreas destroyed.

Useful Tests

The most useful tests in acute pancreatitis are the serum amylase and lipase levels. In this disease the serum amylase is increased 4 to 6 times the normal level (60 to 150 units, Somogyi method) very early and usually returns to normal within 3 to 4 days. The serum lipase is also elevated above its upper limit of normal (1.0 to 1.5 units, Cherry and Crandall method) and remains high after the amylase returns to normal; the test takes so long (24 hours) that it has little usefulness compared with serum amylase (1 hour) when the question of the diagnosis arises in a surgical emergency.

Determination of volume, bicarbonate and enzyme content of the duodenal juice is made before and after injection of stimulants to the external secretion of the pancreas. These stimulants include secretin (1 unit per kilogram of body weight, intravenously) for volume and bicarbonate secretion, and methacholine (15 mg. subcutaneously) or belhanecol (10 mg. subcutaneously) — both parasympathomimetic drugs — for enzyme secretion. END

PATHWAYS OF PANCREATIC FUNCTION



Broken line shows pathway of secretin—released from intestinal mucosa by presence of various substances in the intestine—and its effect upon the acinar cells in increased (↑), decreased (↓) and unchanged output. Dotted line follows pancreozymin route; the solid line that of cholinergic stimuli via vagus and splanchnic nerves.

Water, electrolytes and enzymes are excreted into the duodenum with small amounts of amylase and lipase normally absorbed by blood.

EFFECT OF DISEASES OF PANCREAS ON EXCRETORY FUNCTION

CHRONIC PANCREATITIS

1. Decrease in bicarbonate—early.
2. Decrease in volume—later.
3. Decrease in duodenal enzyme concentration—later.
4. Pancreatic steatorrhea—last.

CARCINOMA OF PANCREAS

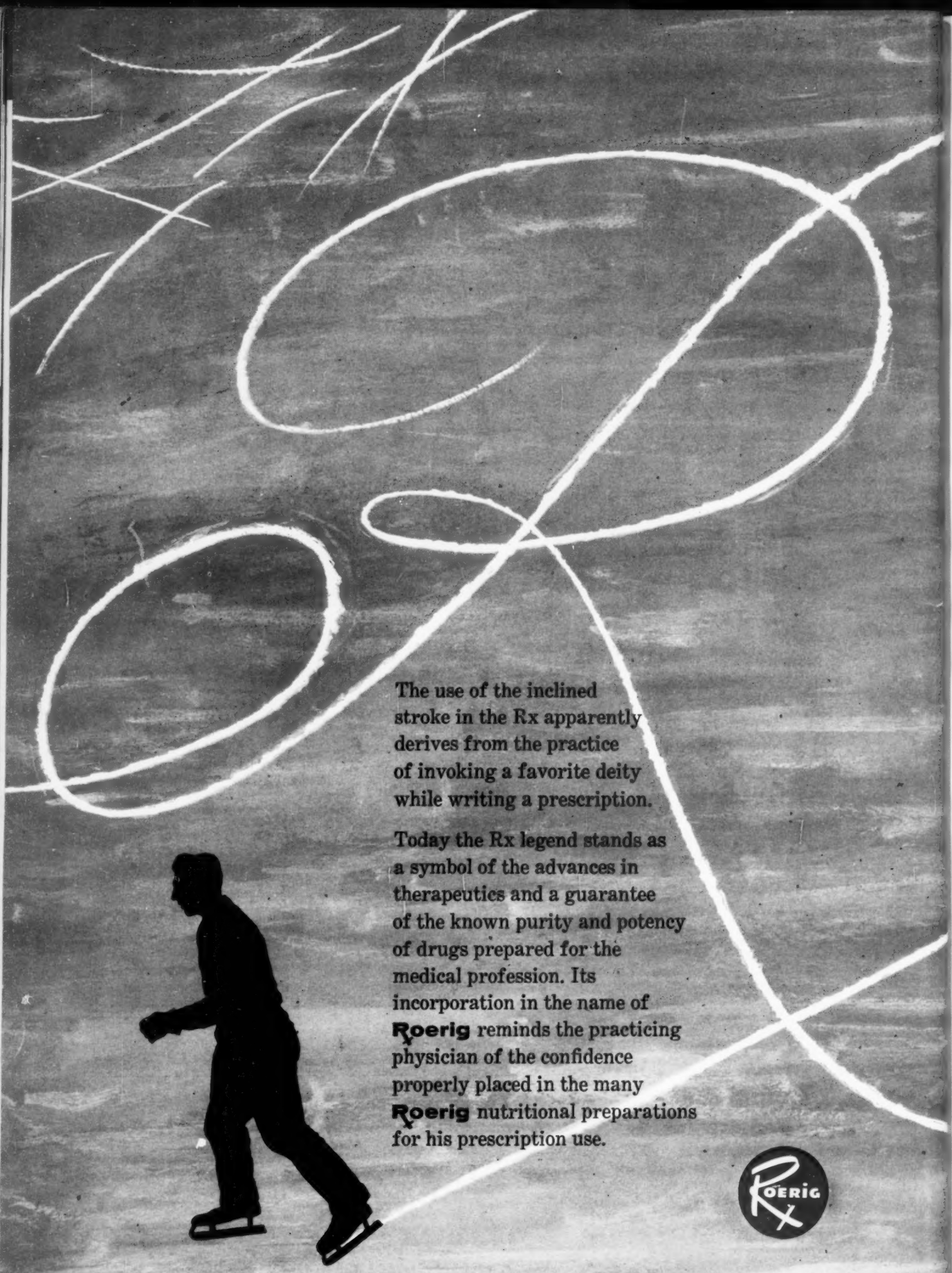
Decrease in volume but with normal amounts of bicarbonate and enzymes.

ACUTE PANCREATITIS

1. Elevated blood amylase and lipase.
2. Volume, electrolytes and enzymes excreted into duodenum usually normal (amylase may be low).

OBSTRUCTIVE LESION AT AMPULLA

1. Decrease in bicarbonate and in volume—early.
2. Decrease in duodenal enzyme concentration—later.
3. Elevated blood amylase and lipase—last.



The use of the inclined stroke in the Rx apparently derives from the practice of invoking a favorite deity while writing a prescription.

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be able to continue

the diuretic you prescribe?

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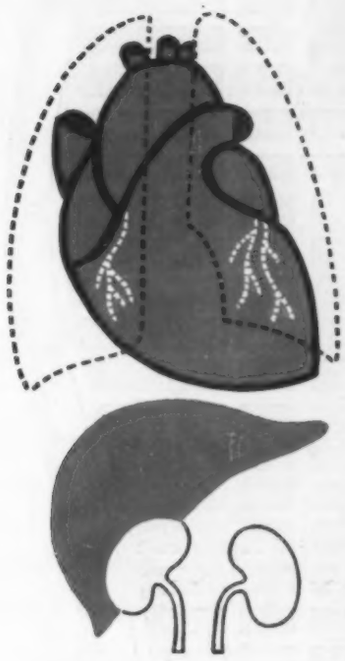

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a standard for initial control of severe failure **MERCUHYDRIN® SODIUM**
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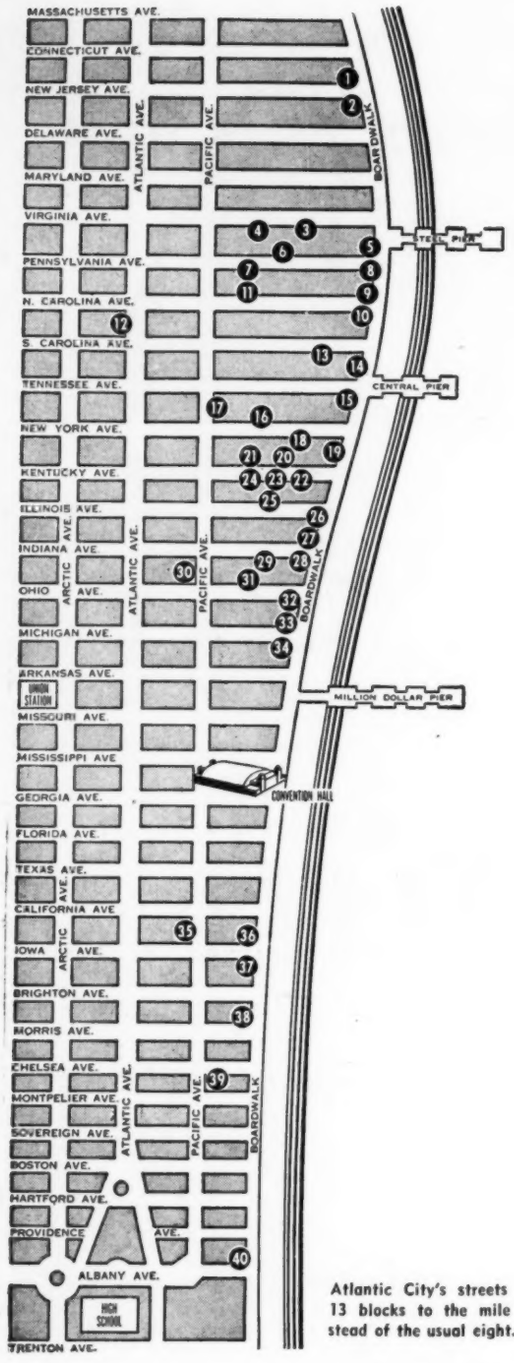

Atlantic City's streets are 13 blocks to the mile instead of the usual eight.

Atlantic City provides a most satisfactory site for the location of the A. M. A. Meeting. Thousands of physicians will spend the week of June 6 to 10 there enjoying the rich professional contacts of the Meeting. The list below includes names of principal hotels, with types of accommodations available, location and cost. *However, the supply of single rooms is limited, and wherever possible, visitors should make arrangements to share double rooms.*

All reservations are to be cleared through the Local Subcommittee on Hotels. Contacting individual hotels will be useless as your application will in any case be referred to the Subcommittee. Use the form at bottom of opposite page, addressing the Chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City, N. J.

SCHEDULE OF RATES

ALL ROOMS WITH BATH †

BOARDWALK HOTELS

Key No.	HOTELS	Rooms with Bath Single	Double
8	ABBEY	$8.00-10.00	$10.00-14.00
37	AMBASSADOR	6.00-20.00	8.00-22.00
1	BREAKERS	5.00-11.00	7.00-18.00
27	BRIGHTON	6.00-10.00	8.00-14.00
9-10	CHALFONTE-HADDON HALL	6.00-10.00	9.00-22.00
38	CHELSEA	6.00- 8.00	8.00-16.00
28	CLARIDGE	7.00-15.00	11.00-19.00
33	DENNIS	7.00- 9.00	10.00-22.00
32	MARLBOROUGH-BLENHEIM	7.00- 9.00	10.00-20.00
15	MAYFLOWER	10.00-11.00	10.00-15.00
14	NEW BELMONT	5.00	7.00-12.00
40	PRESIDENT	5.00-10.00	8.00-17.00
36	RITZ-CARLTON	6.00-10.00	8.00-22.00
2	ST. CHARLES	6.00-10.00	8.00-14.00
5	SEASIDE	7.00-11.00	8.00-16.00
34	SHELBURNE	8.00- 9.00	10.00-25.00
26	TRAYMORE—Headquarters Hotel—No rooms available		

AVENUE HOTELS

Key No.	HOTELS	Rooms with Bath Single	Double
21	BOSCOBEL	$3.50- 4.00	$ 6.00- 7.00
11A	CAROLINA CREST *	.....	10.00-12.00
4	CLARENDON	6.00- 8.00	8.00-10.00
7	COLTON MANOR	7.00-10.00	10.00-14.00
17	COLUMBUS	.....	6.00- 8.00
29	CRILLON *	.....	10.00-14.00
30	EASTBOURNE	.....	8.00-11.00
16	FLANDERS	6.00- 7.00	8.00-12.00
6	HOLMHURST	.....	10.50
23	JEFFERSON	6.00- 8.00	8.00-12.00
24	KENTUCKY	4.00	7.00- 8.00
11	LAFAYETTE	5.00- 8.00	8.00-16.00
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MEDICINE IN THE JUNGLE

Albert Schweitzer, Dr. Med., Lambaréné, French Equatorial Africa

When I decided to go to Africa as a physician I was told by Alsatian missionaries active in the region of the Ogowe River in French Equatorial Africa that there was an urgent need for a physician at Lambaréné. They also told me that that was a very good location for a hospital, because patients could be brought there by way of the Ogowe River and its tributaries. In the jungle forests of Equatorial Africa rivers constitute the best and frequently the only channel of transportation.

I took passage for Lambaréné in the spring of 1913, together with Mrs. Schweitzer, who is a trained nurse. On arrival, I established myself at the station of the Protestant Missionary Society of Paris. I shall always be indebted to this society for having permitted me to live as a guest in one of their houses and for the help they gave me in building a hospital on their ground. The limited means at my disposal would not have permitted me to pay the workers who were needed to clear a piece of land large enough for a house and a hospital. Furthermore, I did not have the experience that was required to clear a piece of land in a jungle and erect buildings. It would also have been a sacrifice on my part if, instead of assuming my medical work at once, I had lost about two years in preparation of a site and in the erection of necessary buildings. All work progresses very slowly in the jungle, because trained and disciplined workers are not available. One has to deal with the primitive natives, who do not have to do paid work to earn their livelihood. They work only as a sort of favor and when and if it suits them. Six months were required to complete a small building for the treatment of patients. It was a barrack built of corrugated metal, which contained a room for consultation, a small operating room, a pharmacy, and a room for sterilizing instruments. While this barrack was being built under the direction of a white missionary craftsman, Negro workers under the direction of a missionary were erecting a large bamboo hut for the housing of patients. During the free time left to me after treating the patients, I myself became an apprentice builder. The first thing I had to learn was which particular hardwoods were suitable as building material, because they were resistant to termites. They had to be differentiated from the softwoods, which the termites would destroy. However, not even all hardwoods are suitable; only those that can be worked with tools are good for building purposes.

Until the building that was to serve for the treatment of patients had been completed, I gave treatment in a small house that adjoined my living quarters and that had formerly been a hen house. My first operation, done on a patient with a large hernia, was performed in the hut of a native. The natives gave me their complete trust and confidence from the beginning. This I owe to a French military physician, who, while traveling through this region toward the interior, once stayed for several weeks at Lambaréné and performed a number of successful operations. The natives honored me by regarding me as his successor, who would, however, remain permanently.

A colonial physician must be a surgeon. This alone makes it possible for him to help many patients. It also gains for him the confidence and the trust of the natives, who are inclined to regard as helpful the powders and solutions given to them by their fetish doctors; in fact, they may trust these even more than the medicines of the white physician. However, the native soon realizes that the white physician is superior to his fetish doctor, when he learns that the white doctor knows how to bring cure with a knife.

BUILDING A NEW HOSPITAL

The bamboo huts, covered with roofs made of the leaves of raffia palms, were large enough to accommodate 40 patients. It was unfortunate that the clearing on the banks of the Ogowe River, on which the mission station was located, was so restricted by swamps and steep hills that more space was not available for my hospital; the disadvantage of a restricted space was impressed on me when, at the end of 1924, large numbers of the natives contracted amebic dysentery. They had lost their resistance to this infection and had become very susceptible to it, because as a result of a famine, they had for some time been deprived of their usual diet of bananas and manioc and instead had eaten imported rice, which they did not tolerate well. The observation that a rice diet predisposed the natives to amebic dysentery I was able to make repeatedly later on.

At this time, when amebic dysentery was prevalent, I had to find housing for many patients. Since I could not isolate them, all rooms in the hospital and even the drinking water became contaminated. The drinking water was obtained by hospital patients from a bay in the river. Thus it happened that patients who came for treatment

of other illnesses contracted amebic dysentery at the hospital. I decided therefore to relocate the hospital on new ground four kilometers upstream. I could dare now to make myself independent, because in the meantime my wings had grown. I had learned how jungle forests can be cleared, and, what is much more difficult than the cutting down of the trees, I had learned how to remove the mighty stumps and their roots. I had also learned something about building. Furthermore, I had acquired as a friend a capable black carpenter, who had been trained at a mission station; his name was Momenzalie. Fortunately also my hospital was now financially in a much better position than at the beginning of my work.

Thus it became possible for me in the course of the year 1925 to prepare the building site and to start building houses. In view of the fact that bamboo huts with palm leaf roofs constantly require repair, I decided that they would not be suitable for the new hospital and that it would be better to house the natives in solid corrugated metal barracks with roofs of corrugated metal. Although one might suspect that such buildings would not be suitable for regions close to the equator because they would be very hot, this great disadvantage can be partially overcome by constructing them in such a manner that air can circulate beneath the gable of the corrugated metal roofs. This provides an escape for the hot air and prevents the rooms from becoming unbearably hot. The temperature does become quite high during the heat of the day because of the roofs; however, this defect is compensated for by the fact that they give better protection against the rain. Moreover, the natives usually spend the day in front of the huts and go inside only during the night.

The main part of the new hospital was completed about midyear of 1927. It provided accommodations for 20 white patients and for 250 natives. The new hospital, like the original one, is located near the river. This is necessary because the natives come to us in their canoes, and they want to stay where they can keep an eye on the canoe and also go fishing.

Since 1924 my wife and I have not been alone at the hospital. We had with us two and occasionally three assistant physicians and eight or nine white nurses.

SLEEPING SICKNESS

When I first came to Lambaréné in 1913, the chief problem was the sleeping sickness that was then ravaging the country. It had not always existed in the region in which we were located but had been prevalent farther to the south, in the region of Loango, and there it did not cause great ravages. The natives of that part of the jungle did not do much traveling about. For this reason, sleeping sickness, which was already talked about by the slave traders of the 17th and 18th centuries, had been restricted largely to these endemic foci. However, when the white traders hired bearers in the Loango region for their commerce, these bearers spread the disease to regions that formerly had been free from sleeping sickness. Now sleeping sickness traveled with the traders, and everywhere many people died from it. When I came to Lambaréné sleeping sickness was in full swing. We then used sodium arsanilate (Atoxyl) to combat the disease. It was dangerous, however, even in small doses, because it could cause blindness by its effect on the optic nerve. Moreover, it was not very effective. Only when after 1920 the German drug suramin (Germanin, Bayer 205) sodium became available, and after we had obtained the American drug tryparsamid, thanks to Miss Pearce, was it possible to treat the disease effectively.

I was active in the campaign against sleeping sickness until 1928. After that the task was taken over by the French colonial government, which organized the campaign in the following manner. Groups of medical assistants, under the direction of physicians, went to the native villages and brought the patients with sleeping sickness to special camps where they were treated. After the patients had been discharged as cured and had been permitted to go back to their villages, they were reexamined at six-month intervals, and, when they had not been definitely cured, they were given another course of treatment. Today it can be said that the campaign against sleeping sickness has been won.

SURGERY AND OBSTETRICS

The surgical department in my hospital now has become of much greater importance. It became the surgical center of a large area. Operations for hernia were perhaps the most numerous. The incidence of hernia is much greater among the black natives of our region than among the whites. We frequently have to operate on patients for incarcerated hernia. The prognosis of this intervention is often quite unfavorable, because the patients do not reach us until the incarceration has existed for several days. The patients have to be carried to us from long distances over jungle paths or they are brought to us in canoes. In many cases in which intestinal gangrene has already set in we find it necessary to resect portions of the intestine, and occasionally we have had greater success with this than we had hoped for. Among the native women pelvic tumors are quite frequent. Urologic surgical intervention is also required by a relatively large number of patients.

We also do a considerable amount of obstetric work. The initial lack of confidence in the white physician as obstetrician has long been given up by the native women. This lack of confidence was due to the conviction of these primitive women that no man should come near a woman in labor. In earlier days, as I was still able to observe when I first arrived here, when a delivery was in progress in a village all men had to remain in their huts. They were permitted to show themselves again only after the delivery had been completed. The births were directed by old women, who resorted to quite senseless procedures in difficult cases. As time progressed, the younger women were able to assert themselves to the extent that, when a delivery did not progress normally, I would be called. After they had observed my successful interventions in a number of cases, it gradually became customary to bring the parturient women into my hospital when delivery proved difficult. Frequently this was done only after the old women had tried their dangerous arts. For this reason I tried to induce the women to come to us for delivery. The resistance on the part of the old women was great. However, I could master this situation in a very simple manner and without many words. Every baby who was born in the hospital was dressed up in a pretty little shirt and a pretty little bonnet, and when the mother returned

to the village she was permitted to take along both of these garments. Among the natives the newborn infant wears nothing for many months, and it lies beside its mother completely naked. Great astonishment was created in the villages when babies born in the hospital had their own little shirt. Against this the old women could do nothing. It became customary for women to come to the hospital for delivery, and many children now remain alive who otherwise would have died. Among my nurses there is always one who has had obstetric training, so that the physicians concern themselves only with the difficult cases. Shirts and bonnets are still given to the babies.

TREATMENT OF LEPROSY

When the efficacy of sulfones against the leprosy bacillus was discovered in America, and when glucosulfone (Promin) and sulfoxone (Diasone) sodium became available for the treatment of leprosy, I was one of the first to use these drugs in Africa. Kind American friends had supplied me with them. The first patient whom I treated with these drugs was a native evangelist of the Protestant mission. His name was Ephe; he had suffered from leprosy for many years and had severe, very painful leprous ulcerations on his feet. Everything I had tried to heal these suppurating and foul smelling ulcerations with had failed. The use of the American drugs now produced the miracle. After a few weeks the sores became cleaner, and after some months they closed completely, so that this man who had been lying on his bed, a picture of misery, was now able to walk about. From then on leprous patients came in larger numbers to my hospital and requested treatment. I settled them in a village of bamboo huts, which I had constructed on a hill in the jungle not far from the hospital. Here they were given daily treatments by a physician and a nurse.

Unfortunately the bamboo huts gave inadequate protection against wind and rain. Furthermore, they last only about three years and have to be replaced by new ones. For this reason, I decided in 1953 that the village of bamboo huts should be replaced by one or more durable buildings. The new buildings have a framework of hardwood, which rests on a wall of reinforced concrete about 30 cm. in height. The roofs, like those of the new hospital, are of corrugated metal. Two patients live together in one room at ground level. A building with kitchens, one for each two patients, is located a short distance from these houses. The patients in the village for the leprous, just like the patients in the hospital, do not receive their food already prepared but are given bananas, manioc, rice, salt, and occasionally dried fish; they cook their own meals from these supplies. The necessary wood for their fires is available in the jungle, which surrounds the village like a green wall. The cooking fat is palm oil, which they obtain from nuts of the oil palms, of which there are hundreds in the large plantations belonging to the hospital. The new village for leprosy patients is still not completed. I hope that it will be finished during the coming months.

I would not like to close this survey on the development of my hospital without expressing heartfelt thanks to my American friends for the help I have received from them. The first shipment of gifts of medicines from America I received during the middle period of the Second World War, when the containers in my pharmacy had become empty, and I also did not know how to pay for the food required by the patients. It was due to American aid that my hospital could continue to operate during the Second World War, after I had been cut off from connections with Europe.

EFFECTS OF ISONIAZID ON PYRIDOXINE METABOLISM

J. Park Biehl, M.D.
and
Richard W. Vilter, M.D., Cincinnati

The person who becomes sick with tuberculosis today is indeed in a far better position than the unfortunate person who had it a decade ago. The list of chemotherapeutic drugs effective in tuberculosis is growing, and "eradicative therapy," a new phrase, is beginning to appear in the literature. Perhaps the most important drug of all is isoniazid. The potent antituberculous effects of this drug have quickly been applied in clinical practice. With its virtual lack of toxicity in the recommended doses of 3 to 5 mg. per kilogram of body weight per day, it is now being used quite commonly and, some physicians think, indiscriminately. The fact that significant pharmacological side-effects result from the use of isoniazid became apparent to us in the course of our studies. In an exploration of the effects of higher doses of isoniazid, conducted by one of us (J. P. B.) over the past 18 months, peripheral neuritis was noted to be a fairly common side-effect. It seemed probable that this neuritis was an effect of a metabolic defect induced by the drug. The similarity of the neuritis to that produced by the vitamin B_6 antagonist, desoxypyridoxine,[1] led us to investigate B_6 metabolism in tuberculous patients receiving isoniazid in various doses. The purpose of this paper is to describe the clinical manifestations of isoniazid neuritis and to present data indicating that isoniazid does

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Florence Beall, Cora Ellen Kennedy, and Helen Glazer gave technical assistance.

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Pyridoxine was furnished by Merck and Company, Inc., Rahway, N. J. Isoniazid was furnished by E. R. Squibb and Sons, New York, and the William S. Merrell Co., Cincinnati.

1. Vilter, R. W., and others: Effect of Vitamin B_6 Deficiency Induced by Desoxypyridoxine in Human Beings, J. Lab. & Clin. Med. 42: 335 (Sept.) 1953.

alter B_6 metabolism and that neuritis may be prevented with large doses of pyridoxine. All subjects were adults with active tuberculosis, who were patients in either Cincinnati General Hospital or Dunham Hospital. All received streptomycin daily or twice weekly and partook of the regular hospital diet. The clinical parts of the study were performed concurrently. Leading questions concerning neuritis were avoided by the examiner, to eliminate the factor of suggestion; however, remarks by the patients that might possibly be connected with the onset of neuritis were carefully pursued.

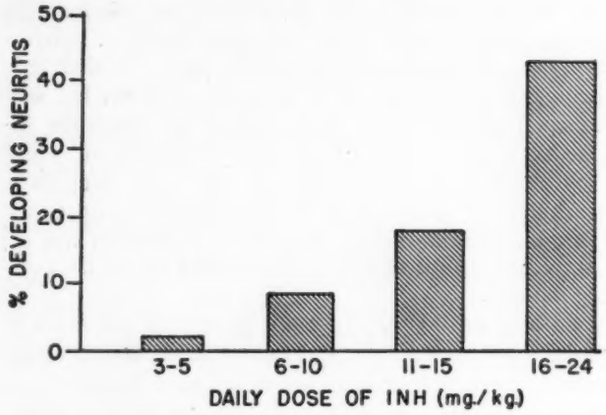

Fig. 1.—Incidence of peripheral neuritis due to isoniazid, or isonicotinic acid hydrazide, according to dose of isoniazid administered.

FEATURES OF THE NEURITIS

Seventy-four previously untreated patients received daily doses of isoniazid ranging from 6 to 24 mg. per kilogram of body weight. This was continued for from 2 to 12 months unless toxicity supervened. Peripheral neuritis appeared in 19 of these patients. Figure 1 indicates the incidence of neuritis according to the dose of isoniazid the patient received. Those in the highest dose range, 16 to 24 mg. per kilogram per day, showed the highest incidence; in 14 of 32 patients, or 44%, neuritis developed. The first column indicates four other patients, not otherwise included in this study, in whom neuritis appeared while they were receiving only the standard dose of isoniazid, representing 2% of all those receiving this low dose in the same period of time. The time when neuritis appeared after isoniazid therapy was started is shown in figure 2. Patients receiving the standard dose showed no symptoms until six months had elapsed; in those given high doses symptoms frequently developed in five weeks. When high doses of isoniazid were given to patients who had been receiving the drug previously in standard doses, neuritis appeared much sooner than in patients who had not received the drug before; thus, seven patients previously given conventional doses had symptoms within a week after their daily dose was raised to 11 mg. per kilogram.

The manifestations of neuritis are bilateral and peripheral, consisting of paresthesia, numbness, burning pain, and weakness. Physical findings include hypesthesia and exaggerated or absent tendon reflexes, but in the earlier stages objective findings are usually absent. If isoniazid is withdrawn promptly, symptoms will disappear within a few weeks; however, residual difficulties may persist for a year or more if therapy is continued for more than a few weeks after the onset of symptoms. Further details of the neuritis have been published elsewhere.[2] Of interest is the fact that neuritis apparently does not occur in children receiving high doses of isoniazid or in monkeys.[3]

EFFECT OF ISONIAZID ON METABOLISM OF VITAMIN B_6

After admission to the hospital, patients were observed for a few days, and control samples of urine were obtained. The drug to be studied was then started; 12 patients received the high dose of isoniazid, 6 were given the standard dose of 3 to 5 mg. per kilogram per day, and one was treated with streptomycin and *p*-aminosalicylic acid. Serial 24 hour urine samples were analyzed for excretion of vitamin B_6[4]; pyridoxic acid,[5] an inactive metabolite of B_6; and a major excretion form of nicotinic acid, N^1-methylnicotinamide.[6] A test was also employed

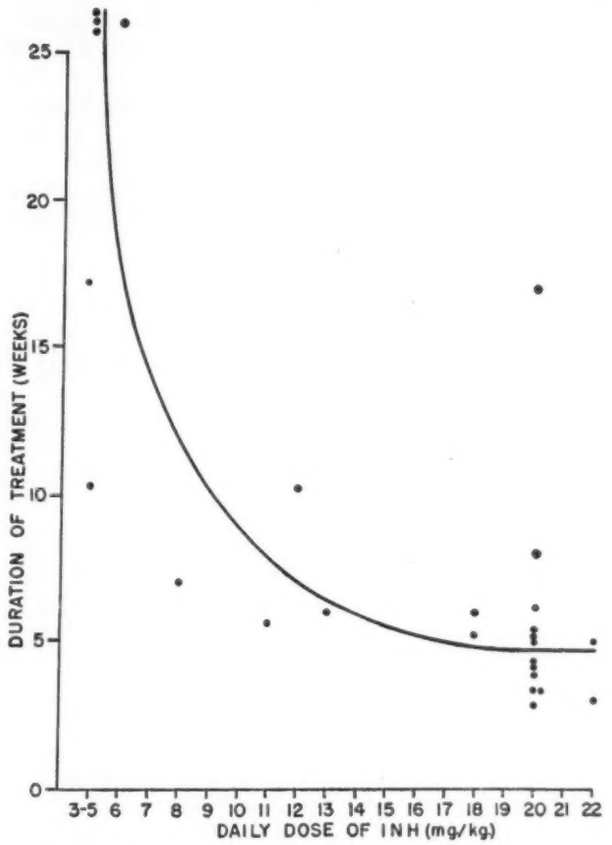

Fig. 2.—Time of onset of isoniazid neuritis, according to dose of isoniazid administered.

2. Gammon, G. D.; Burge, F. W., and King, G.: Neural Toxicity in Tuberculous Patients Treated with Isoniazid (Isonicotinic Acid Hydrazide), A. M. A. Arch. Neurol. & Psychiat. **70**: 64 (July) 1953. Biehl, J. P., and Skavlem, J. H.: Toxicity of Isoniazid, Am. Rev. Tuberc. **68**: 297 (Aug.) 1953. Biehl, J. P., and Nimitz, H. J.: Studies on Use of High Dose of Isoniazid, Am. Rev. Tuberc. **70**: 430 (Sept.) 1954.

3. Schmidt, L. H.: Personal communication to the author.

4. Atkin, L.; Schultz, A. S.; Williams, W. L., and Frey, C. N.: Yeast Microbiological Methods for Determination of Vitamins. Pyridoxine, Indust. & Engr. Chem., Anal. Ed. **15**: 141 (Feb. 15) 1943. Rabinowitz, J. C., and Snell, E. E.: Vitamin B_6 Group. XV: Urinary Excretion of Pyridoxal, Pyridoxamine, Pyridoxine, and 4-Pyridoxine Acid in Human Subjects, Proc. Soc. Exper. Biol. & Med. **70**: 235 (Feb.) 1949.

5. Sarett, H. P.: Study of Measurement of 4-Pyridoxic Acid in Urine, J. Biol. Chem. **189**: 769 (April) 1951.

6. Huff, J. W., and Perlzweig, W. A.: N^1-Methylnicotinamide, A Metabolite of Nicotinic Acid in the Urine, J. Biol. Chem. **150**: 395 (Oct.) 1943.

for the detection of B_6 deficiency.[7] Since B_6 is necessary for the normal metabolic breakdown of the amino acid tryptophane, a deficiency in B_6 results in an abnormal breakdown. The abnormal breakdown product that appears when B_6 is deficient is xanthurenic acid; we therefore gave test doses of tryptophane and interpreted the appearance of xanthurenic acid in the urine in high quantities as indicative of B_6 deficiency.

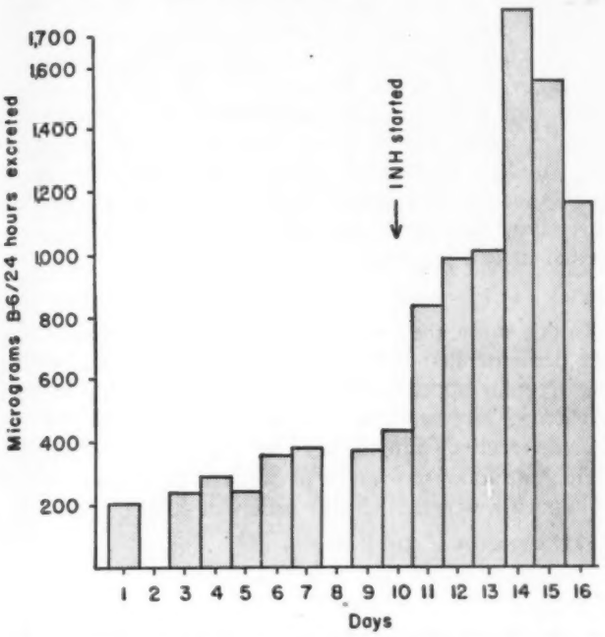

Fig. 3.—Effect of isoniazid (20 mg. per kilogram per day) on vitamin B_6 excretion.

An example of the effect of the high dose of isoniazid on the excretion of vitamin B_6 is shown in figure 3. A control period of nine days, during which the patient received streptomycin only, preceded isoniazid therapy. The day after isoniazid therapy was begun, there was a striking increase in the excretion of B_6. Increases up to four times the normal excretion are shown. Figure 4 shows the average B_6 excretion of all patients receiving the high dose of isoniazid, the standard dose, and no isoniazid. In each patient receiving isoniazid, excretion of B_6 was increased, the most striking elevations appearing in the group taking high doses. No increase was seen under identical conditions when *p*-aminosalicylic acid was substituted for isoniazid. Excretion of B_6 promptly fell to normal when isoniazid was withdrawn. Excretion of pyridoxic acid and of the nicotinic acid metabolite was normal in all patients. Excretion of xanthurenic acid after test doses of tryptophane showed a progressive but slower rise in some, but not all, patients receiving the high dose of isoniazid; when pyridoxine was given, a prompt fall to normal occurred. The same phenomena were also observed in some patients receiving the standard dose; they were not seen in patients receiving streptomycin-*p*-aminosalicylic acid.

EFFECT OF PYRIDOXINE ON ISONIAZID NEURITIS

Twenty previously untreated patients were given 20 mg. per kilogram of isoniazid, together with 50 to 450 mg. of pyridoxine daily. These patients were observed on this regimen for at least 10 weeks, and in none did neuritis appear; it should be recalled that, ordinarily, when this dose of isoniazid is unaccompanied by pyridoxine, neuritis develops in 40% of the patients, usually within 8 weeks. In another series, three patients were given pyridoxine when isoniazid neuritis developed, and isoniazid therapy was continued. In two the subjective manifestations were not affected by pyridoxine, so that after 3 and 16 days isoniazid therapy was stopped. In the third, relief was obtained for nine weeks; then our supply of pyridoxine was temporarily exhausted, and neuritis reappeared. In a series of cases in which late residual isoniazid neuritis persisted after isoniazid therapy had been stopped, the effects of pyridoxine and of a niacin-thiamin mixture were tested in two groups of matched cases. No change was noted in either group, but the refractory nature of late neuritis from any cause is recognized.

COMMENT

Mechanisms other than interference with vitamin B_6 have been suggested as being responsible for isoniazid neuritis, in particular metabolic antagonism of nicotinamide by isoniazid. If this were the case, pellagra would be the expected clinical manifestation. Neuritis is not seen in nicotinamide deficiency; furthermore, there was no disturbance in our cases in the excretion of the nicotinic acid metabolite. On the other hand, neuritis has been produced by B_6 deficiency in animals [8] and human beings.[1] Vitamin B_6 is an essential nutrient, required as a coenzyme in certain vital biochemical mechanisms. Three metabolically active forms of the vitamin exist:

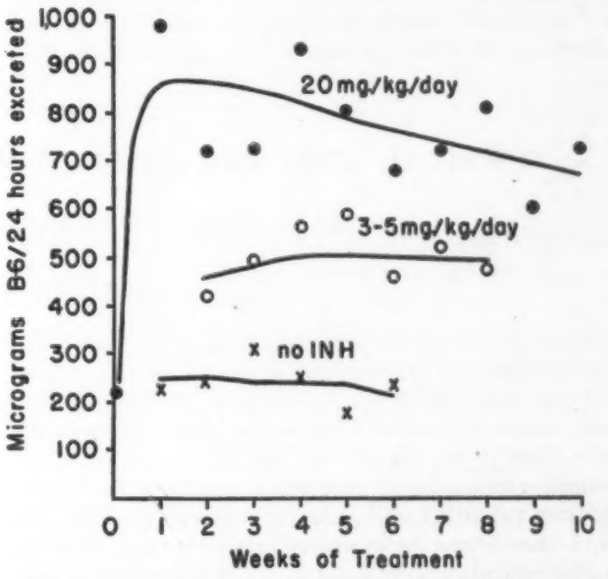

Fig. 4.—Average values of vitamin B_6 excretion during treatment with high doses of isoniazid, standard doses, and no isoniazid.

pyridoxal, pyridoxamine, and pyridoxine. It is probable that the phosphate of pyridoxal is the ultimate active form. Clinical manifestations of vitamin B_6 deficiency have been described only recently. Such a deficiency in

7. Glazer, H. S., and others: Study of Urinary Excretion of Xanthurenic Acid and Other Tryptophane Metabolites in Human Beings with Pyridoxine Deficiency Induced by Desoxypyridoxine, Arch. Biochem. 33: 243 (Sept.) 1951.

8. Follis, R. H., and Wintrobe, M. M.: Comparison of Effects of Pyridoxine and Pantothenic Acid Deficiencies on Nervous Tissues of Swine, J. Exper. Med. 81: 539 (June) 1945.

infants may result in convulsions.[9] When a deficiency state is induced in adults by administration of desoxypyridoxine, seborrheic dermatitis, glossitis, cheilosis, and peripheral neuritis have been observed.[1]

We found in this study that the expected 40% incidence of neuritis seen with the use of high doses of isoniazid is abolished by concurrent medication with pyridoxine; it is not to be assumed, however, that substances unrelated to vitamin B_6 may not have played some part in producing neuritis in our patients. The incidence of neuritis in tuberculosis itself is considerable, and vitamin B_6 deficiency may represent but one of several factors involved. We also found that a striking increase in B_6 excretion may be accompanied by laboratory evidence of an actual deficiency in the vitamin. Preliminary data indicate that the B_6 vitamin excreted in excess in these patients is pyridoxal. It is inferred from these observations that isoniazid neuritis is at least in part a manifestation of vitamin B_6 deficiency, although a true cause and effect relationship cannot be proved at this time. The data do not support the thesis of metabolic antagonism. Additional experiments have led us instead to the hypothesis that isoniazid depletes the tissues of B_6 by the formation and excretion of the isonicotinyl hydrazone of pyridoxal. The formation of this compound can be demonstrated in the test tube; it is brought about by the coupling of pyridoxal and isoniazid at the carbonyl and free amino groups, respectively. Its properties recently have been described by Sah.[10]

The possible adverse effect of pyridoxine on the antituberculous quality of isoniazid is an important question. We have been unable to show any inhibition of the tuberculostatic effects of isoniazid by pyridoxal or pyridoxine in the test tube, although Pope[11] reports initiation of growth in tubes containing minimal inhibitory concentrations of isoniazid by the addition of 10 mcg. of pyridoxal per milliliter. The few patients who received high doses of isoniazid with pyridoxine in this series showed a good therapeutic response that was indistinguishable from that of controls receiving isoniazid without pyridoxine. The phenomenon described in this paper, the creation of a specific vitamin deficiency by a medicament in common use, is of general interest because, so far as is known, it is unique; it is quite possible, however, that other drugs newly added to our therapeutic armamentarium may also have detrimental effects on metabolic processes of great importance to the human body. One wonders, in particular, about other hydrazide compounds such as hydralazine hydrochloride (Apresoline). This report represents only the first chapter in the approach to this problem.

SUMMARY

In this study, the excretion of an excess of vitamin B_6 was demonstrated in patients receiving isoniazid, with the irregular appearance of laboratory evidence of B_6 deficiency. The effect was found to be more marked in patients receiving a higher than normal dose of isoniazid. Pyridoxine added to the dose of isoniazid prevents peripheral neuritis, which otherwise occurs in 40% of cases.

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SURVIVAL AND REHABILITATION AFTER CORONARY OCCLUSION

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and
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When the diagnosis of acute coronary occlusion first became clinically feasible, the prognosis of the patient with an acute attack and his outlook for long survival were considered doubtful. However, during the past 20 years, two of us (A. M. M. and H. L. J.) have repeatedly expressed their optimism concerning both recovery from the attack and subsequent ability to work.[1] In 1935, they found the mortality rate to be only 10% in private patients who suffered from the first attack of coronary occlusion.[1a] At present, the mortality rate in these patients has dropped to 5%. This very encouraging figure, lower than that found in ward patients, is the result of improved diagnosis and methods of treatment. Our diagnostic acumen, aided by the routin use of 12 leads in the electrocardiogram, has become sharpened in coronary thrombosis. This has led to earlier diagnosis and the detection of many mild and atypical attacks, particularly in young men, who now have an excellent chance of recovery. One of the first important advances in therapy was the giving of a low calory diet, instead of the previous common practice of overfeeding.[1a] Underfeeding during the first week of the attack reduces the work of the heart and diminishes gastrocardiac reflexes. Another improvement in therapy followed the realization that drugs such as digitalis and quinidine sulfate should be used judiciously, and that other drugs, such as epinephrine (Adrenalin) and glyceryl trinitrate (nitroglycerin), should be avoided. More recently, the use of anticoagulant and vasoconstrictor drugs in indicated cases has further contributed to the hopeful outlook in coronary occlusion.

In follow-up studies after the acute attack, it was found that most patients had made a complete or satisfactory recovery and were working.[1c] Many of these had already

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1. (*a*) Master, A. M.: Coronary Artery Thrombosis with Treatment by Prolonged Rest in Bed and Low Calorie Diet: Improved Prognosis, J. A. M. A. **105**: 337 (Aug. 3) 1935. (*b*) Master, A. M., and Dack, S.: Rehabilitation Following Acute Coronary Occlusion, ibid. **115**: 828 (Sept. 7) 1940. (*c*) Master, A. M., and Jaffe, H. L.: Complete Functional Recovery After Coronary Occlusion and Insufficiency, ibid. **147**: 1721 (Dec. 29) 1951.

lived 10 or more years after the attack. Over the years, other authors have also reported the outlook after coronary occlusion to be favorable, and many have confirmed our view that these patients are able to work without aggravation of their disease.[2] Recent investigations in England suggest that persons with coronary disease who do heavy work, such as bus conductors and postmen, are even less prone to have acute coronary episodes than are those engaged in sedentary work, e. g., executives, clerks, and telephone operators.[3] In a recent study, the average period of survival after coronary occlusion was found to be more than eight years.[2h] Case reports of patients who have lived for from 20 to 40 years after an occlusion have been published.[4] The fairly good prognosis even in cases of ventricular aneurysm has been emphasized.[5] This report is a continuation of the follow-up study of the cases previously reported [1c] and includes 88 additional cases, making a total of 500. In order to evaluate properly their functional recovery, only those patients who had survived the coronary occlusion for at least one year were included in this series. In all the cases, the diagnosis of coronary occlusion was confirmed electrocardiographically by the presence of Q waves and RS-T elevation. Patients with acute coronary insufficiency with subendocardial ischemia or necrosis (infarction), showing only RS-T depression and/or T wave inversion, were excluded,[6] since they had been included in the previous study.[1c] Ninety per cent of the patients were seen in private practice, and 10% were ward patients.

METHOD

In order to evaluate their degree of recovery, the patients were divided into four groups on the basis of symptoms (group 1, 2, 3, and 4) and into four subdivisions on the basis of objective findings (subdivision A, B, C, and D). There were thus 16 possible combination groups, e. g., 1A, 2B, 3C, 4D.

Group 1 included patients without cardiac symptoms, i. e., they experienced neither anginal pain nor dyspnea. Group 2 comprised patients with mild angina or dyspnea on exertion. Group 3 consisted of patients in whom these symptoms were more severe and sometimes appeared at rest. Group 4 included patients with intractable angina or dyspnea. Patients with normal or essentially normal results of physical examination, fluoroscopy, and 12-lead electrocardiogram were in subdivision A. Some of the electrocardiograms had small Q waves or low T waves that were within normal limits, although probably the end-result of the previous infarction. Subdivision B comprised patients with mild cardiac enlargement or electrocardiographic abnormalities, while subdivision C was composed of those patients in whom these changes were marked and in whom ventricular aneurysm was not infrequently present. Patients with definite congestive failure were included in subdivision D. In each case, the period of survival was measured from the date of the first attack of coronary occlusion.

FINDINGS

Of the 500 patients studied, 415 were men and 85 were women, a ratio of 5 to 1. The average age at which the initial acute coronary occlusion developed was 53.3 years. It was almost identical in the four groups. After the attack, 209 of the 500 patients (41.8%) were asymptomatic, having made a complete functional recovery (group 1). Two hundred thirteen patients (42.6%) experienced mild anginal pain or dyspnea on exertion, but their activity was only slightly restricted, if at all (group 2); thus, more than four out of every five patients made either an excellent or a satisfactory recovery. Fifty patients (10%) suffered from moderate anginal pain or dyspnea (group 3), and 28 patients (5.6%) had intractable angina or dyspnea (group 4, table 1). Although the 209 patients in group 1 were asymptomatic, only 32 had no definite objective findings (1A). In some, small Q waves or rather low T waves were present in the electrocardiogram, but they were within normal limits. Almost 3 out of every 4 patients (145 of 209) had mild to moderate cardiac enlargement or residual electrocardiographic abnormalities (1B). The remaining 32 patients fell into group 1C. These were of great interest, because, though they had marked cardiac enlargement or electrocardiographic changes, they were asymptomatic. In 12 of these 32 patients, a definite diagnosis of ventricular aneu-

TABLE 1.—*Degree of Recovery and Mortality in 500 Patients After Coronary Occlusion*

Group	No. of Patients Living	No. of Patients Dead	Mortality Rate, %
1A	30	2	
1B	120	25	
1C	27	5	
1D	0	0	
	177	32	15.3
2A	7	0	
2B	116	30	
2C	33	20	
2D	3	4	
	159	54	25.4
3A	0	0	
3B	11	6	
3C	16	10	
3D	5	2	
	32	18	36
4A	0	0	
4B	1	1	
4C	4	1	
4D	8	13	
	13	15	53.8
Total	381	119	23.8

2. (*a*) Parkinson, J., and Bedford, D. E.: Cardiac Infarction and Coronary Thrombosis, Lancet **1**: 4, 1928. (*b*) Bland, E. F., and White, P. D.: Coronary Thrombosis (with Myocardial Infarction): Ten Years Later, J. A. M. A. **117**: 1171 (Oct. 4) 1941. (*c*) Levine, S. A., and Rosenblum, F. F.: Prognostic Value of Various Clinical and Electrocardiographic Features of Acute Myocardial Infarction: II. Ultimate Prognosis, Arch. Int. Med. **68**: 1215 (Dec.) 1941. (*d*) Crain, R. B., and Missal, M. E.: The Industrial Employee with Myocardial Infarction: His Ability to Return to Work, Arch. Indust. Hyg. **1**: 525 (May) 1950. (*e*) Sigler, L. H.: Prognosis of Angina Pectoris and Coronary Occlusion: Follow-Up of 1,000 Cases, J. A. M. A. **146**: 998 (July 14) 1951. (*f*) Goldwater, L. J.; Bronstein, L. H., and Kresky, B.: A Comparison of Working and Non-Working Cardiac Patients, A. M. A. Arch. Indust. Hyg. **5**: 485 (May) 1952. (*g*) Smith, C.: Length of Survival After Myocardial Infarction, J. A. M. A. **151**: 167 (Jan. 17) 1953. (*h*) Cole, D. R.; Singian, E. B., and Katz, L. N.: Long-Term Prognosis Following Myocardial Infarction and Some Factors Which Affect It, Circulation **9**: 321, 1954.

3. Morris, J. N., and others: Coronary Heart Disease and Physical Activity of Work, Lancet **2**: 1111, 1953.

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5. Penner, S. L., and Peters, M.: Longevity with Ventricular Aneurysm: Report of a Case with a Survival Period of Fifteen Years, New England J. Med. **234**: 523, 1946. Footnote 1c.

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rysm was made on the basis of a visible bulge in the left ventricular contour, or of a reversal of pulsation, and of persistent RS-T elevation and Q waves in the electrocardiogram. Only seven patients in group 2 (those with mild angina or dyspnea on exertion) failed to show some roentgenologic or electrocardiographic alteration (2A). As in the asymptomatic patients in group 1, almost three-fourths of the patients in group 2 (146 of 213) showed mild or moderate cardiac enlargement or electrocardiographic changes (2B). Of the remaining 60 patients in group 2, 53 had marked cardiac enlargement or electrocardiographic alterations, including ventricular aneurysm (2C), and 7 gave evidence of occasional mild congestive failure (2D). In group 3 (those with moderate angina or dyspnea), the majority of patients showed advanced roentgenologic and electrocardiographic changes (3C). In group 4, congestive failure, as well as marked graphic alterations, was present in 75% of the cases (4D).

TABLE 2.—*Length of Survival, in Years, of 500 Patients After Coronary Occlusion*

Patients	Total	Under 5	Between 5 and 9	Between 10 and 15	Over 15
Living					
Group 1	177	62	75	34	6
2	159	97	43	15	4
3	32	17	10	4	1
4	13	8	3	2	0
	381	184	131	55	11
Dead					
Group 1	32	9	10	10	3
2	54	23	18	11	2
3	18	8	5	4	1
4	15	11	2	2	0
	119	51	35	27	6

Mortality Rate and Cause of Death.—Of the 500 patients, 3 out of every 4 (381) were alive at the time of this study. This finding is similar to those of other observers.[2h] As was to be expected, the mortality rate was lowest in group 1 (15.3%) and highest in group 4 (53.8%) (table 1). The rate was relatively low in group 2 (25.4%) and was fairly high in group 3 (36%). The cause of death was determined in 97 cases. Death was found to have been caused by cardiovascular disease in 88.6% of the cases (86). This finding is in conformity with the observations of other writers.[7] A fatal coronary occlusion or insufficiency developed in 56 patients, and 21 died of complications of coronary disease, congestive heart failure, 18; peripheral arterial embolus, 1; ventricular tachycardia, 1; and pulmonary embolism, 1. A cerebrovascular accident was the cause of death for four patients. Five patients died suddenly, probably from acute coronary artery disease. Eleven patients (11.4%) died of noncardiac causes, of which malignant disease was the most frequent. In patients who died, the first coronary occlusion developed at a slightly older age than in the patients who are still alive, the average ages being 55.2 and 52.8 years respectively.

Time of Survival.—Of the 381 patients alive at the time of this report, 51.7% (197) had survived the attack for more than 5 years, 17.3% (66) were alive 10 or more years after the attack, and 11 patients were living 15 or more years later (table 2). The longest survival period was 29 years. The average period of survival was 7.2 years, as has been reported by others.[2h] The duration of survival varied in each group. In group 1 (those who had no cardiac symptoms), 65% of the patients had survived for more than 5 years and 22.6% for more than 10 years. In group 2 (those with mild angina or dyspnea), the corresponding figures were 39% and 12%. Even in groups 3 and 4 (those with serious complaints) about half of the patients had lived for more than 5 years, and about 16% had survived for more than 10 years. The average period of survival of those who died ranged from 8.3 years in group 1 to 3.5 years in group 4. It was 7.4 years in group 2 and 6.6 years in group 3. Of the patients in group 1, 71.9% lived more than 5 years before death, and 40.6% lived 10 years or more. In group 2, the corresponding figures were 57.4% and 24.1%. In groups 3 and 4, almost half the patients lived at least five years before death occurred. The incidence of anterior and posterior infarction was almost the same in the four groups and in the living and dead. The location of the infarction does not influence the prognosis, either during the acute attack or thereafter.

Ability to Work.—The postocclusion work history was obtained in 343 patients (table 3). Of these, 69.7% were working full or part time. This figure closely approaches those previously reported.[8] As was to be expected, the number of working patients was greatest in groups 1 and 2. Of 152 patients in group 1 (those without cardiac symptoms), 64.5% (98) were working full time and 20% (31) were at part-time work. Only one out of six or seven of these patients was not employed.

TABLE 3.—*Extent of Work After Coronary Occlusion in 343 Patients (Total Series 500)*

Group	Full Time	Part Time	No Work
1A	23	2	0
1B	66	19	19
1C	9	10	4
	98 (64.5%)	31 (20.0%)	23 (15.5%)
2A	3	1	4
2B	43	25	40
2C	9	9	9
2D	1	0	0
	56 (38.9%)	35 (24.3%)	53 (36.8%)
3A	0	0	0
3B	1	3	1
3C	2	5	7
3D	1	5	9
	4	13	17
4A	0	0	0
4B	0	0	2
4C	0	0	3
4D	0	2	6
	0	2	11
Total	158 (46.1%)	81 (26.3%)	104 (30.3%)

Of 144 patients in group 2 (those with mild angina or dyspnea), 38.9% (56) were working full time and 24.3% (35) were at part-time work; thus, 74.5% of the patients in groups 1 and 2 were working. It it safe to assume that the number of patients able to work was much greater, since many cardiac patients are afraid of resuming work or remain idle on the advice of their physicians. Of 34 patients in group 3, 4 did full-time work and 13 were at part-time work. Two patients in group 4 were at part-time work. The patients in groups 1 and 2 were

7. Footnotes 2*c* and *h*.
8. Footnotes 1*b*, *c*, and 2*h*.

engaged in various professions and in many trades, and most resumed their original type of work. Included were physicians, lawyers, business executives, bankers, tailors, dress operators, salesmen, painters, truckmen, taxicab drivers, policemen, farmers, and laborers.

COMMENT

The present study confirms our previous findings concerning the favorable long-term prognosis of acute coronary occlusion. Over two-fifths of the patients made a complete functional recovery, and a similar number experienced only mild symptoms; thus, four out of every five patients made an excellent or satisfactory recovery. Most of these patients (67.5%) were employed. During the past 15 years, it has been our practice to advise such patients to return to work. It is likely that this number could have been significantly increased if others had been encouraged to work by their physicians. It appears that 75 to 85% of the patients who survive an acute coronary occlusion are able to perform gainful work, and it is important that they do so. After a coronary occlusion, most patients are filled with fear and anxiety. They assume that they will be unable to work and will be invalided. The patient's family, friends, and physician often further aggravate their anxiety and stress their incapacity for work. As a result, numerous nervous symptoms are apt to develop, particularly pain in the chest that may be difficult to distinguish from cardiac pain. These nervous symptoms may incapacitate even those patients who, otherwise, might have recovered completely. The most effective way to prevent this psychoneurotic state is to encourage the patient by the earliest possible chair treatment during the acute attack and by early resumption of gainful employment. The fear of financial dependence plays almost as much psychological havoc with these patients as does the anxiety about their heart condition, for many patients with coronary occlusion are in the most productive period of their lives. In any case, it is unnecessary and inadvisable to prohibit these patients from working, for it has been found that their work performance is usually very satisfactory and that their health and life span are not affected by work.[9] Our patients who resumed work fared as well as did those who had retired; subsequent coronary occlusion or heart failure was not more apt to develop in them nor was their mortality rate increased. These patients thus tend to support the contention that effort does not precipitate coronary occlusion, although it may induce coronary insufficiency.[10] It is of interest that 11 patients who had made a complete functional recovery and in whom a second coronary occlusion later developed again became symptom free and resumed work.

In each case, the physician must decide when the patient can and should return to work and must determine the type of work that can be safely undertaken. The majority of patients who have made a good recovery returned to work three to six months after the attack. Sometimes, an even earlier return to work is possible; occasionally, recovery is slower, and the patient becomes well enough to resume work only after a year. A patient who is well one year after the attack has an excellent chance of surviving for many years. Many patients are able to resume their usual occupations, even manual labor,[1c] but others cannot do so and should seek lighter work. Vocational guidance and selective job placement are essential in these cases. The physician can perform a great service in directing the patient back to a productive life, but the problem goes beyond the private physician and requires the close cooperation of the local medical societies, industry, and social and government agencies. Although much remains to be done, a great deal has already been accomplished in finding suitable work for cardiac patients. Work classification units, workshops for cardiac patients, vocational guidance and rehabilitation centers, and selective placement studies have been developed. Employers are urged to engage persons with heart disease through a concentrated publicity campaign. Some states, through second injury laws, have attempted to stimulate their employment by means of an equitable adjustment of the liability that an employer must assume when hiring a disabled worker. Periodic examinations should be made to determine whether any change in the type of work done is necessary. As a general policy, these patients should not be placed in positions in which the occurrence of attacks of anginal pain will endanger the lives of others. Most patients who recover from an acute coronary occlusion not only resume work but live much longer than is generally believed. Of the 336 living patients who had made a complete or satisfactory recovery, more than half have already lived more than 5 years and almost one-fifth have survived for more than 10 years. Furthermore, of all the patients who had made a complete or good recovery, only one-fifth have died. Of the patients who died, 62% lived more than 5 years and 30% survived for 10 years or more. The average period of survival was almost eight years. Of those who had made a complete recovery, only nine died less than five years after the attack; thus, patients in this group have a 95% chance of surviving for at least five years. It is evident, however, that a patient may recover completely from his first occlusion and another may develop after a lapse of time. As expected, 9 out of 10 patients died of cardiovascular disease.

The reason for the present improved outlook for patients after coronary occlusion is not hard to find. In recent years, the diagnosis of coronary disease and occlusion has become increasingly accurate. As a result, mild and atypical cases are more often detected. This leads to earlier treatment of the acute attack and, as a result of the advances in therapy, to more complete recovery. The cardinal principles in treatment are a sensible, low calory diet for the first week or two, the proper administration of drugs when indicated, and the use of anticoagulants, vasopressor drugs, and antibiotics in selected cases. Our findings clearly indicate that the patient's history after the attack, i. e., the presence of symptoms and the ability to do things, is the best guide to the degree of recovery and to the long-term prognosis. The symptoms and the working capacity are far more significant than are cardiac enlargement, marked electrocardiographic changes, or a prolonged sedimentation rate. This is well illustrated by

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10. Master, A. M., and Jaffe, H. L.: Factors in the Onset of Coronary Occlusion and Coronary Insufficiency: Effort, Occupation, Trauma, and Emotion, J. A. M. A. **148**: 794 (March 8) 1952.

the group of patients who had made a complete functional recovery and were asymptomatic. Thirty-two of these symptomless patients (15.3%) had greatly enlarged hearts and marked electrocardiographic changes. In almost half of these patients, a definite diagnosis of ventricular aneurysm was made. Yet, only five have died, and a significant percentage have lived for more than 10 years. The longest survival period in this entire series (29 years) fell into this group. The most important prognostic indicator, in patients who have recovered from coronary occlusion, is how the patient feels. Nevertheless, if the physical examination, electrocardiogram, heart size, and pulsations become normal, the patient has probably made an excellent recovery, and his outlook is good. Of 39 patients with normal objective findings, 32 were asymptomatic (group 1A) and 7 experienced occasional mild angina (group 2A). Only 2 of the 39 have died. It is hoped that the findings presented in this and in previous reports will gradually dissipate the widespread pessimism among physicians and laymen about coronary occlusion. More and more, medical and heart associations are disseminating the facts about the disease and enlisting the aid of industry in placing cardiac patients at work. More remains to be accomplished. Physicians should join in encouraging these patients to be productive and independent. The problem, however, can be solved only by the cooperation of the entire community.

SUMMARY

In a follow-up study of 500 patients who had survived a coronary occlusion for from 1 to 29 years, it was found that 2 out of every 5 patients had made a complete functional recovery. A similar number made a satisfactory recovery, in that they experienced only mild anginal pain or dyspnea on exertion. Three-quarters of these patients were, for the most part, working. Over half of the patients had already lived more than five years after the attack, and one out of every five survived for more than 10 years. Among the patients who made a complete or a satisfactory recovery, only one out of every five died. Death usually occurred as a result of another coronary occlusion or of congestive failure. The most reliable gauge of recovery after coronary occlusion is the absence of cardiac symptoms, regardless of the objective findings. Many patients who have made a complete or good functional recovery have large hearts, marked electrocardiographic changes, and, not infrequently, ventricular aneurysm. Nevertheless, when the physical examination, electrocardiogram, heart size, and cardiac pulsation are normal, the patient has almost always made an excellent recovery and his outlook is good. Another coronary occlusion may develop many years later in patients who have recovered completely, and they may again recover fully. The site of the infarction does not affect the prognosis after coronary occlusion. The outlook is somewhat better in younger patients. The patient and the physician should be optimistic about the prognosis in coronary occlusion, both during the attack and afterward. The majority of patients survive for many years and lead productive lives. The outlook for patients who return to work is at least as good as it is for those who retire. The medical profession should take the lead in acquainting the public with these facts and should enlist the cooperation of business and of social agencies in placing the cardiac patient in industry.

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HEMATOLOGICAL ALTERATIONS AFTER TOTAL GASTRECTOMY

EVOLUTIONARY SEQUENCES OVER A DECADE

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Between 1944 and 1949 total gastrectomy was performed for gastric carcinoma in 63 patients by members of the surgical staff of the Johns Hopkins Hospital, principally by Longmire [1] and Scott.[2] Subsequently 17 patients have undergone this procedure, so that at the present time there is a series of 80 patients who have had a total gastrectomy. Many of these patients were seen preoperatively and have been carefully studied postoperatively at frequent intervals during this 10 year period in the gastroenterological clinic by one of us (M. P.).

There are profound physiological changes in these patients as a result of the anatomic alteration. There is decreased capacity for ingesting food; frequent feedings of small amounts are necessary. There are profound nutritional and metabolic changes, with resulting mild steatorrhea, inability to digest complex carbohydrates, attacks of postprandial hypoglycemia and hypokalemia (dumping syndrome), and failure to gain weight.[3] There are chronic inflammatory changes in the lower esophagus and jejunum about the anastomotic site, the latter visualized on jejunoscopy.[4] There is a characteristic radiographic pattern, with dilatation of the terminal esophagus

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The measurement of radioactive material recovered in the stool of the patient in case 11 was done by Dr. Julius R. Krevans as part of a study on the absorption of cobalt 60—labeled vitamin B_{12}. Results of this study are to be published.

Dr. C. L. Conley and his associates in the Hematology Clinic gave help and advice and prepared and interpreted all the bone marrow studies done on the patients included in this study.

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2. Scott, H. W., Jr., and Longmire, W. P., Jr.: Total Gastrectomy: Report of 63 Cases, Surgery **26**: 488, 1949.

3. Paulson, M.: in Peptic Ulcer: Clinical Aspects, Diagnosis, Management, Sandweiss, D., editor, Philadelphia, W. B. Saunders Company, 1951, chap. 47, p. 518.

4. Paulson, M.: Peroral Jejunoscopy and Duodenoscopy: Endoscopy of Uppermost Small Intestine After Total Gastrectomy, Gastroenterology **23**: 593, 1953.

and contiguous jejunum or duodenum and disturbances in the pattern of the small intestine. There are profound hematological changes. All of these changes are so definite and follow such a characteristic pattern that they may be called the "total gastrectomy syndrome." [3]

This paper deals with the hematological changes and their evolution in these patients. An iron deficiency anemia developed shortly after operation. Within two years macrocytosis developed in the peripheral blood, and, if the patients lived long enough, a true macrocytic megaloblastic anemia developed.

OBSERVATIONS

Of the 80 patients in this series, 27 have been followed adequately hematologically. Some patients died too early after operation to allow adequate examination of the blood other than in the immediate postoperative period. Frequent examinations of the peripheral blood were made. Bone marrow examinations were done immediately postoperatively and approximately at six month intervals. Gastric analyses were done on 23 of the patients before operation. Nineteen of these patients had free acid, and four had achlorhydria even after histamine stimulation.

There were 21 men and 6 women in this group. Eighteen were Negro and nine were white. The youngest was 35 and the oldest 65 at the time of operation; the majority were between 40 and 55 years of age. Predominance of the Negro patients reflects only the role the clinic plays in serving as "family physician" for a large segment of the indigent Negro population living in the immediate vicinity of the hospital; it by no means implies any specific ratio incidence of gastric carcinoma.

In all cases the preoperative diagnosis was gastric carcinoma. Total gastrectomy was performed in each instance, and the surgical specimen was carefully studied. The pathological diagnosis was gastric carcinoma in 23 patients, lymphosarcoma in 2, benign ulcer in one, and chronic gastritis in one. Shortly after operation an iron deficiency anemia developed in these patients. This may be seen in the peripheral blood within two or three months after operation. The only anemia occurring before operation in a few of these patients resulted from bleeding of the gastric lesion. This was always corrected preoperatively by transfusions.

The iron deficiency resulted from the slow loss of blood from the inflamed and eroded areas in the lower part of the esophagus and, principally, in the jejunum. The stools of these patients gave positive guaiac reactions. Many patients in whom macrocytosis developed had had iron deficiency anemia earlier, i. e., within months after operation. The iron deficiency was controlled by the administration of ferrous gluconate or sulfate, 0.3 gm. three times a day, though the stools of the patients gave intermittent positive guaiac reactions. In 1945, three patients who died with widespread metastases 3 months, 11 months, and 12 months after operation showed at the time of death severe iron deficiency anemia. Thus, it soon became evident that iron deficiency was inevitable; therefore, the patients operated on after 1945 were given daily supplements of iron. We feel this practice accounts for a normal peripheral blood picture in five patients who died within the first year after operation.

In four of the patients in whom macrocytic anemia had developed a severe iron-deficiency type of anemia developed terminally. Serum iron levels measured in two of these patients were 34 mcg. per 100 ml. of blood and 31 mcg. per 100 ml. of blood. Normal values exceed 70 mcg. per 100 ml. of blood. During autopsy in two patients, new carcinomas were found in the transverse colon. In the two other patients, who were not seen at autopsy, x-ray studies showed, in one, a lesion in the transverse colon and, in the other, a lesion in the descending colon. The radiographic interpretation of these lesions was carcinoma, but whether they were primary or metastatic is unknown.

Table 1 shows the time after total gastrectomy at which macrocytosis, anemia, and megaloblasts in the bone marrow developed. The table includes all 19 patients in whom macrocytosis developed. Seven are alive at the time of this report. In only one of the 19 did combined systemic disease develop. Macrocytosis always developed first, and, in those who lived longer, anemia developed second and megaloblastic marrow third. This was the usual sequence. The time of appearance of macrocytosis after operation varied (the shortest period being one-half and the longest seven years), as did the time between the appearance of macrocytosis, the development of anemia, and the development of megaloblastic marrow. This variation is shown in figure 1. The macrocytosis developed about the second year after operation. The anemia followed within one or two years. Megaloblasts developed in the marrow only after anemia had been detected in the peripheral blood. This development occurred usually three to five years after operation.

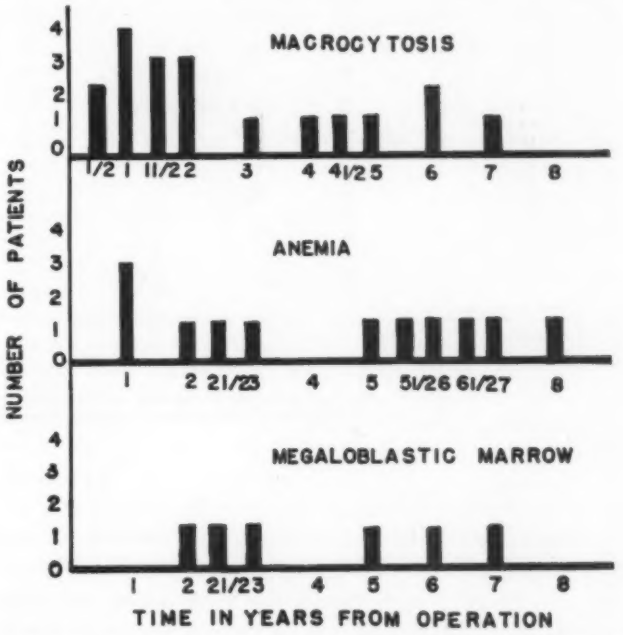
MACROCYTOSIS
ANEMIA
MEGALOBLASTIC MARROW
NUMBER OF PATIENTS
0
1
2
3
4
1/2 1 11/2 2 3 4 4 1/2 5 6 7 8
1 2 2 1/2 3 4 5 5 1/2 6 6 1/2 7 8
1 2 2 1/2 3 4 5 6 7 8
TIME IN YEARS FROM OPERATION

Fig. 1.—Chart showing the evolution of hematological changes toward macrocytic-megaloblastic anemia in 27 patients who had total gastrectomy.

Table 2 gives the results of treatment of those patients in whom a macrocytic-megaloblastic type of anemia developed fully. The time treatment was instituted is shown as well as the drug used, route of administration, dosage, and the response as measured by rise of hematocrit, decrease in mean corpuscular volume of

erythrocytes, and disappearance of megaloblasts from the marrow. The patient in case 11 had a deficiency of folic acid as well as a deficiency of vitamin B_{12}. He responded further, as shown by hematocrit rise and cell volume fall, to orally administered folic acid after there had been maximum response to parenterally administered vitamin B_{12}. The response to orally administered folic acid in another patient (case 10) who had had maximum response to vitamin B_{12} was clouded by development of severe iron deficiency resulting from loss of blood in the intestine, subsequently proved at autopsy to be loss from an ulcerating primary carcinoma of the transverse colon.

A study of the absorption of vitamin B_{12} from the intestine by the use of vitamin B_{12} labeled with cobalt 60 was done on one patient (case 11) who returned to the clinic after a lapse of two years during which he had no therapy. He again had macrocytosis, severe anemia, and megaloblasts in the bone marrow. One-half of a microgram of vitamin B_{12} labeled with cobalt 60 was given orally, and recovery of the radioactive material was measured in the stool. Approximately 87% of the radioactive material was recovered in the stool. Approximately 10 to 40% of this same oral dose was recovered in the stools of normal persons.

The changes in the bone marrow of one patient who had had a total gastrectomy are shown in figures 2 and 3. The bone marrow was obtained from the patient one and three years after operation. Figure 2 shows normal marrow, and figure 3 shows the megaloblastic type of marrow. At this time the patient's hematocrit was 33, and the mean corpuscular volume was 136. After six months of vitamin B_{12} therapy, the marrow returned to normal. Just prior to the development of macrocytosis, this patient showed atrophy of the jejunal mucosa not unlike the atrophy of gastric mucosa seen in pernicious anemia. This atrophy is seen in the photomicrographs of the jejunal biopsies obtained at jejunoscopy (fig. 4 and 5).

TABLE 1.—*Data on Patients Who Underwent Total Gastrectomy*

Case	Age, Yr.	Sex	Time After Gastrectomy, Yr.		Gastric Lesion	Gastric Analysis *		Time at Which Hematological Findings First Appeared After Gastrectomy, Yr.		
			To Death	To Present		Free Acid †	Total Acid †	Macrocytosis	Anemia	Megaloblastic Marrow
1	46	M	1	..	Carcinoma	18	24	½	—	Not examined
2	46	F	1½	..	Carcinoma	10	20	1	1	Not examined
3	49	M	1½	..	Carcinoma	0	0	1	1	Not examined
4	60	M	1½	..	Carcinoma	10	10	1	1	—
5	64	M	2	..	Carcinoma	Not done		1½	—	Not examined
6	47	M	2	..	Carcinoma	5	14	½	—	Not examined
7	63	M	2	..	Carcinoma	0	0	1½	—	—
8	50	M	3	..	Carcinoma	Not done		2	—	—
9	59	M	3½	..	Carcinoma	4	10	2	3	—
10	58	F	5¼	..	Carcinoma	20	68	2	2½	3
11	57	M	..	5½	Chronic gastritis	5	15	1½	2	2½
12	53	M	..	6	Lymphosarcoma	0	0	1	—	—
13	38	F	..	6	Carcinoma	20	34	5	6	—
14	58	M	6	..	Carcinoma	0	0	3	—	—
15	44	M	..	6½	Carcinoma	10	20	6	6½	6½
16	69	M	7	..	Benign ulcer	14	45	4½	5	5
17	62	M	..	9	Carcinoma	42	66	6	8	—
18	51	M	..	9½	Carcinoma	10	25	4	5½	6
19	54	F	..	15	Lymphosarcoma	10	30	7	7	Not examined

* Preoperative. † Degrees.

TABLE 2.—*Hematological Response to Treatment in Patients Who Had Undergone Total Gastrectomy*

Case	Time Patient First Treated After Gastrectomy, Yr.	Treatment	Response		
			Peripheral Blood		Marrow
			Hematocrit	Mean Corpuscular Volume	
10	3	B_{12}, 150 mg. IM, each week for 8 weeks; the same every mo. for 6 mo.	30 35	136 90	Megaloblasts disappeared
		The same plus folic acid, 15 mg. orally, every day	37	81	
11	2½	B_{12}, 30 mg. IM, each week for 4 weeks; the same each mo. for 6 mo.	30 39	120 95	Megaloblasts disappeared
		The same plus folic acid, 15 mg. orally, each day	44	86	
		Lapsed therapy for 2 yr.	32	122	Megaloblasts reappeared
		B_{12}, 5 mg. orally, and 1 mg. orally each week for 4 weeks	No response	No response	No response
		B_{12}, 45 mg. IM, each week for 5 weeks	40	88	Megaloblasts disappeared
16	4½	B_{12}, 50 mg. IM, each week for 8 weeks and each mo. for 26 mo.	33 36	119 83	Megaloblasts disappeared
18	6	B_{12}, 30 mg. IM, each week for 8 weeks and then each mo. for 24 mo.	30 45	122 89	Megaloblasts disappeared
19	7	Folic acid, 600 mg. IV, each day for 14 days	No response	No response	Not examined
		Crude liver, 45 units IM, each week for 10 weeks and then each mo. for 12 mo.	25 44	128 87	Not examined

COMMENT

In the last decade, total gastrectomy has been performed with increasing frequency. Prior to this, only isolated reports of the operation with follow-up studies on the patients appeared in the literature. More recently

two series of patients who have had a total gastrectomy have been reported by MacDonald, Ingelfinger, and Belding [5] and Blake and Rechnitzer.[6] A summary of the literature appears in each of these articles.

In all of the patients, iron deficiency anemia developed within a few months after operation. This was observed in the other reported series. The iron deficiency occurs as a result of slow bleeding at the ulcerated surfaces in the esophagus and jejunum about the anastomotic site and contiguous inflamed areas. Occult blood is present in the stools of these patients. Supplemental doses of iron can overcome the deficiency. The iron can be given orally and is adequately absorbed from the intestine in these patients.

Within one or two years after operation, patients may show macrocytosis of the red blood cells in the peripheral blood and bone marrow. This may not occur, however, until five or even seven years after operation. Within a variable period of time after the development of macrocytosis, usually another one to two years, anemia will develop if the patient survives. Very soon after anemia is present, megaloblasts will be found in the bone marrow. In MacDonald's series only two patients surviving two and five years after operation had a macrocytic anemia, but bone marrow studies were not done. In Blake's series of 10 patients alive from nine months to three years after operation, 6 had macrocytic anemia at the time the report was written; of these 3 had bone marrow examinations, and all 3 had megaloblasts in the marrow. In the present series, macrocytosis developed in 13 patients within three years after operation.

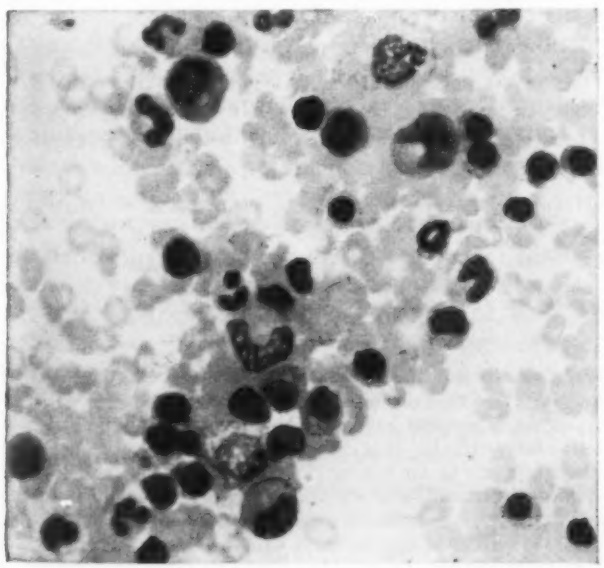

Fig. 2.—Photomicrograph showing normal sternal marrow smear of patient in case 10 one year after total gastrectomy (× 500).

Seven of these died with this blood picture. In the remaining six, anemia developed about one year after the macrocytosis was first noted on the blood smear. Megaloblasts appeared in the marrow of three of these within a year after the development of anemia. Five other patients in this series lived five years after operation before macrocytosis developed; the macrocytosis was followed then within a year or two by anemia and megaloblastic marrow. One patient was first found to have macrocytosis seven years after operation and presently, nine years after operation, is just beginning to have a fall in the hematocrit. It appears, then, that, if patients survive long enough after total gastrectomy, macrocytic-megaloblastic anemia will develop. Though this can occur as early as five months after operation,[7] macrocytic-megaloblastic anemia usually occurs two years or more after operation and manifests itself in stages with macrocytosis first, anemia second, and megaloblastic marrow third.

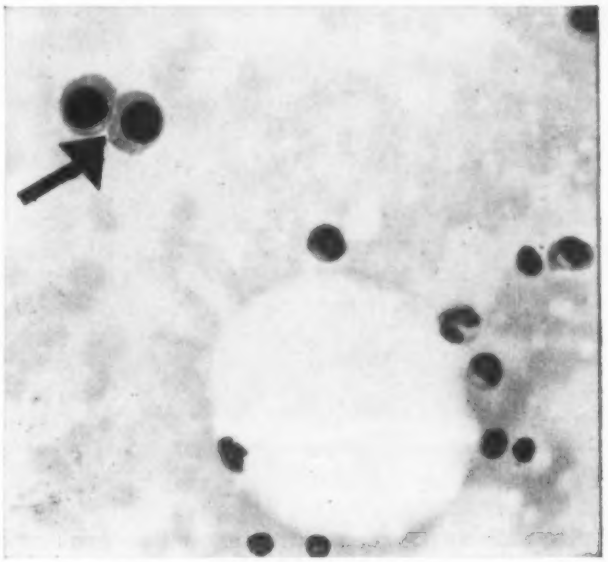

Fig. 3.—Photomicrograph showing sternal marrow smear of patient in case 10 three years after total gastrectomy when patient had macrocytosis and severe anemia. Megaloblasts in the marrow shown by arrow (× 500).

It is not known why the appearance of this type of anemia is delayed. Paulson, Conley, and Gladsden [8] found that intestinal juice aspirated from the jejunum of three of the patients mentioned above (cases 10, 16, and 18) within one year of operation and when each had an entirely normal blood picture produced no hematological response when administered orally in large quantities with ground beef muscle to a patient with pernicious anemia in relapse. The patient did subsequently respond to the parenteral administration of liver. These data show either that there is no substance produced in the duodenum and jejunum that contains intrinsic factor activity or that, if such a substance is produced, it is not produced in great enough amounts or is not present in sufficient quantity in the type of material used to bring about a hematological response in a person with pernicious anemia who can respond to therapy. Landboe-Christensen, Berk, and Castle [9] showed that

5. MacDonald, R. M.; Ingelfinger, F. J., and Belding, H. W.: Late Effects of Total Gastrectomy in Man, New England J. Med. **237**: 887 1947.

6. Blake, J., and Rechnitzer, P. A.: The Haematological and Nutritional Effects of Gastric Operations, Quart. J. Med. **22**: 419, 1953.

7. Ungley, C. C.: A Case of Complete Gastrectomy Followed by Pernicious Anemia, New Castle M. J. **10**: 192, 1952.

8. Paulson, M.; Conley, C. L., and Gladsden, E. S.: Absence of Intrinsic Factor from Intestinal Juice of Patients Following Total Gastrectomy, Am. J. M. Sc. **220**: 310, 1950.

9. Landboe-Christensen, E.; Berk, L., and Castle, W. B.: Observations on Etiologic Relationship of Achylia Gastrica to Pernicious Anemia: Intrinsic Factor Activity of Desiccated and Defatted Human Fundus Duodenum, and Jejunum, Am. J. M. Sc. **224**: 1, 1952.

human duodenal tissue that was obtained at autopsy, mixed with beef muscle, and given to two patients with pernicious anemia caused a hematopoietic response. They believed this indicated presence of intrinsic factor, but they could not determine whether this was intrinsic factor produced by the duodenum or whether it was gastric intrinsic factor passively absorbed by the duodenum. The jejunal atrophy observed by one of us [4] suggests destruction of a possible source of intrinsic factor activity.

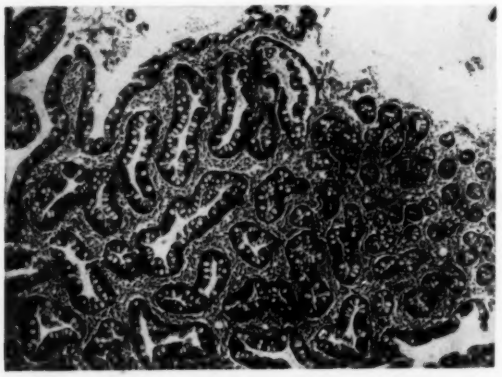

Fig. 4.—Photomicrograph showing normal jejunal mucosa obtained by biopsy at jejunoscopy in patient in case 10 one year after total gastrectomy (× 60).

Krevans' studies point out that orally administered vitamin B_{12} was not absorbed from the intestine of one of these patients. This fact is confirmed by the studies of Swendseid, Halsted, and Libby.[10] These workers used a technique similar to Krevans' and found that orally administered vitamin B_{12} was not absorbed in the intestine of four patients without macrocytosis or anemia who had had total gastrectomies. When normal gastric juice was administered along with the vitamin B_{12} to these patients, there was normal absorption from the intestine. These data show that vitamin B_{12} is not absorbed in the stomach alone but can be absorbed in the intestine of these patients when normal gastric juice is administered with it.

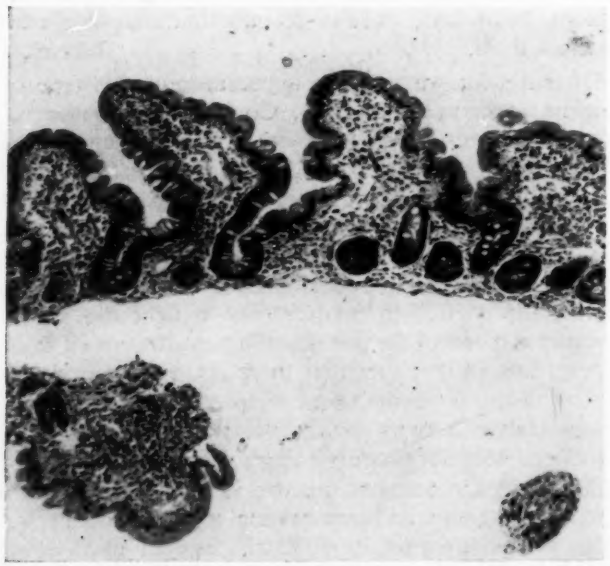

Fig. 5.—Photomicrograph showing atrophied jejunal mucosa obtained by biopsy at jejunoscopy in patient in case 10 three years after total gastrectomy (× 43).

From the data presented here, there is evidence that iron salts and folic acid can be absorbed in the intestine without the presence of normal gastric juice and can correct deficiencies when administered in large doses orally. This is in contrast to vitamin B_{12}, which cannot be absorbed in the intestine without the presence of normal gastric juice. Current studies, however, suggest there is reason to believe that vitamin B_{12} can be adequately absorbed from the intestines of those who have had total gastrectomy if the oral dose is at least 1 mg.[11] It is interesting that another case such as ours with deficiency of both vitamin B_{12} and folic acid following total gastrectomy was recently reported by Conway and Conway.[12]

The patients with macrocytic-megaloblastic anemia following total gastrectomy do respond well to parenterally administered vitamin B_{12}. Five of our patients were so treated, and all showed rise in the hematocrit, disappearance of macrocytosis, and disappearance of the megaloblasts in the bone marrow.

SUMMARY

In studying the effects of total gastrectomy on erythropoiesis in 27 patients, at varying intervals over a decade, the evolutionary sequences found were: First, an iron deficiency anemia results shortly after operation, because blood is lost from ulcerated areas at the anastomotic site. Ferrous salts administered orally will correct the deficiency. Next, macrocytosis of red blood cells occurs within one to two years after operation; if the patients live long enough, this will invariably be followed by anemia and, still later, by the development of megaloblasts in the bone marrow. In patients in whom this macrocytic-megaloblastic type of anemia develops, response in obtained from the parenteral therapy with vitamin B_{12}. Patchy jejunal atrophy not unlike the gastric atrophy seen with pernicious anemia has been encountered and may play a role in the development of this primary anemia.

11 E. Chase St. (2) (Dr. Paulson).

10. Swendseid, M. E.; Halsted, J. A., and Libby, R. L.: Excretion of Cobalt 60-Labeled Vitamin B_{12} After Total Gastrectomy, Proc Soc. Exper. Biol. & Med. **83**: 226, 1953.

11. Paulson, M.; Chow, B. F., and Okuda: To be published.

12. Conway, N. S., and Conway, H.: Vitamin B_{12} and Folic Acid in Megaloblastic Anaemia After Total Gastrectomy, Brit. M. J. **1**: 158, 1951.

Stress and Chronic Ulcerative Colitis.—The relationship between periods of emotional stress and the onset and exacerbation of symptoms in patients having chronic ulcerative colitis has been well established. In addition, distinct personality features and behavior patterns have been found in these patients. . . . A unique opportunity to study the function and behavior of the human colon was presented in four fistulous subjects. . . . Increased rhythmic contractility, sustained contractions, hyperemia, engorgement, hypersecretion of lysozyme, and the secretion of a thick tenacious mucus was observed in all fistulous subjects during periods of anxiety or anger. We believe that the engorged mucosa and the continued hyperfunction lead to submucosal bleeding and ultimately to ulceration. Finally, the increased lysozyme may contribute to the damage by eroding the mucous membrane. The engorged, fragile, eroded mucous membrane is probably easily invaded by indigenous fecal microorganisms, or is further damaged by the action of substances normally present in the fecal stream. . . . Sustained feelings of anger and resentment associated with sustained hyperfunction of the colon result in submucosal bleeding and ulceration.—W. J. Grace, M.D., Life Stress and Chronic Ulcerative Colitis, *Annals of the New York Academy of Sciences*, July 15, 1954.

SURGICAL MANAGEMENT OF DEGENERATIVE LUNG DISEASE

Gerald L. Crenshaw, M.D., Oakland, Calif.

Since the days of Laennec, altered pulmonary physiology that results in progressive loss of lung tissue has been designated as emphysema and has been attributed, according to Laennec's theory, to an interference in the free flow of air between the alveolus and the bronchus. After 1949, surgical observations of these altered lungs made this theory untenable. A great deal of time has been spent in studying, by indirect methods, the relationship between the amount of air ventilated and the absorption of oxygen by the pulmonary vascular bed. Little attention has been paid to the role of the bronchial arterial system in maintaining the viability of these structures. To make the picture more complex, the function of capillary and precapillary anastomoses between the bronchial arterial and pulmonary arterial systems has been shown by Liebow.[1] The true nature and function of these shunts are still a research problem. Tobin and Zariquiey,[2] in their excellent studies of the normal anatomy of the bronchial arterial system and its ramifications, and Cudkowicz and Armstrong,[3] in their work demonstrating the role of the bronchial arteries in disease, have helped to present a clearer picture of the importance of the bronchial arteries. Their function may be twofold: primarily, they are nutrient, but in certain cases, as in tetralogy of Fallot with pulmonary arterial atresia, they may be life-sustaining in their ability to bring venous blood to the pulmonary capillaries for oxygenation. We know that in tuberculosis and bronchiectasis, as well as in other infectious diseases of the lungs, the bronchial arterial system is increased. Bierman and co-workers [4] have demonstrated that the bronchial arteries furnish the blood supply to tumors, and they are using this fact as a basis for the use of chemotherapy in bronchogenic carcinoma.

CLINICAL MANIFESTATIONS

The bronchial arteries are part of the general systemic vascular system, as they are branches of the thoracic aorta and thus may be affected by any of the peripheral vascular diseases. By their multiple origin and plexiform distribution to the bronchi, the vasa vasorum of the pulmonary arteries and veins, and the mediastinal structures and lung parenchyma, nature has protected these vital structures against sudden obliteration by embolization. Pure gangrene of the lung without anaerobic infection is seldom, if ever, seen; however, the telangiectatic formation of the bronchial arteries cannot prevent slow obliterative changes as seen in diseases like generalized arteriosclerosis. It was to show the effect of this type of obliteration that this paper was written. We have been able to demonstrate, by serial sections of a bronchus of a patient with degenerative lung disease, the progressive obliteration of the bronchial arteries within the wall of a bronchus and its effect on that bronchus and the lung tissue to which it leads. Slow obliteration of bronchial arteries by inherent disease produces an altered physiological state that can best be understood at surgery, while these degenerated lungs are being subjected to ventilation and the tissues are still connected to both blood systems. In these bronchi and lungs, the effects are commonly generalized, with gradations from some loss of elasticity of the lung to complete obliteration of lobar bronchi and pulmonary arteries and veins of an entire lobe. Cudkowicz and Armstrong [3b] have demonstrated, in postmortem studies by retrograde filling, that the bronchial arteries are likewise obliterated, often back to the region of the hilus.

As the bronchial arterial system is the common factor affecting all structures in the lung, this slow obliteration produces: (1) a paucity or lack of bleeding in this normally extremely vascular organ; (2) bullous degeneration, which is a non-air-trapping phenomenon taking place within the parenchyma of the lung; (3) replacement of the normal, delicate, transparent, visceral pleura with a coarse, avascular, parchment-like structure; and (4) in extreme cases, complete degeneration of lung structure, with the formation of huge, stretched cysts that may take the greater portion of inspired air away from viable ventilating lung where it could be utilized. On the basis of these facts, the treatment of this condition consists of: (1) surgical removal of the grossly degenerated, air-robbing portion of the lung by segmental or lobar resection; (2) thoracic sympathectomy to open up the remaining viable bronchial arterial channels; (3) vagotomy to lower the pulmonary arterial pressure; and (4) parietal pleurectomy and resection of the endothoracic fascia to make the lung adhere to the periosteum and the intercostal muscles, thus stimulating the ingrowth of systemic, nutrient, collateral circulation.[5]

METHODS OF EXAMINATION

In general, patients with degenerative pulmonary disease are not seen clinically until the disease has progressed to advanced stages. This is because it is insidious in onset and is not incapacitating until it reaches the advanced stages. Most of these patients have never had bronchial asthma, episodes of bronchial spasm, bronchiolitis, or bronchial infection as seen in bronchiectasis, although these may be complicating factors. At first, their only complaint is dyspnea on exertion, which is similar to that seen in cardiac disease and is relieved by rest; however, as the disease advances, such patients may become orthopneic. On physical examination, these patients are usually

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Read in the Panel Discussion on Treatment of Nontuberculous Chest Diseases before the Section on Diseases of the Chest at the 103rd Annual Meeting of the American Medical Association, San Francisco, June 25, 1954.

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2. Tobin, C. E., and Zariquiey, M. O.: Some Observations on the Blood Supply of the Human Lung, Med. Radiog. & Photog. **29**: 9, 1953.

3. (*a*) Cudkowicz, L.: The Blood Supply of the Lung in Pulmonary Tuberculosis, Thorax **7**: 270, 1952. (*b*) Cudkowicz, L., and Armstrong, J. B.: The Bronchial Arteries in Pulmonary Emphysema, ibid. **8**: 46, 1953.

4. Bierman, H. R., and others: Intra-Arterial Catheterization of Viscera in Man, Am. J. Roentgenol. **66**: 555, 1951.

5. Crenshaw, G. L., and Rowles, D. F.: Surgical Management of Pulmonary Emphysema, J. Thoracic Surg. **24**: 398, 1952. Crenshaw, G. L.: Degenerative Lung Disease, Dis. Chest **25**: 427, 1954.

thin, with an increased anteroposterior chest diameter, and, as one watches them, they inspire by lifting the rib cage with their accessory muscles of respiration and expire by the dropping of the rib cage. The chest is surprisingly quiet to auscultation, but, where areas of functioning lung remain, one may hear localized, normal, vesicular breathing.

On fluoroscopic examination, large areas of bullous degeneration often can be seen. The diaphragm is flattened with little or no movement, denoting the loss of elasticity

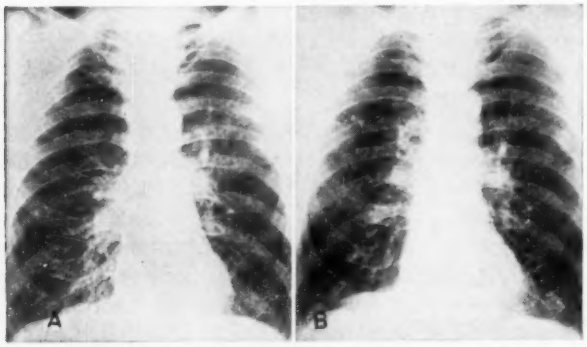

Fig. 1 (case 1).—*A*, roentgenogram made Jan. 18, 1951, showing areas of increased radiolucency throughout the right lung, most marked at the apex and at the base. The left lung appears comparatively normal aside from an old fracture of the sixth rib. *B*, roentgenogram made March 9, 1953, two years after surgery, showing reduction of the radiolucency and no progress of the degenerative changes.

and inability to pull the diaphragm back to its normal, relaxed, dome-shaped position. On the roentgenogram, one notices the increased anteroposterior diameter and areas of translucency. It is impossible to tell from the roentgenogram how much functioning lung remains in the chest. Bronchograms show failure of filling in the larger degenerated areas. Pulmonary ventilatory studies are not generally helpful, as most of the patients are first seen in far-advanced stages with insufficient pulmonary reserve to undergo such tests; however, in those patients who can tolerate them, these studies show reduced inspiratory reserve capacity, markedly reduced maximum breathing capacity, and increased residual air. Angiography offers the best evaluation of the status of the pulmonary arterial system, allowing an estimate of how much functioning lung remains and how much is destroyed. By the number of pulmonary arteries remaining, one can predict the extent of improvement the patient may receive from surgical intervention.

Although these patients may be markedly dyspneic, they tolerate surgery remarkably well because of the positive pressure anesthesia, which forces oxygen into the functioning lung remaining and because the degenerated areas can be manually compressed when the pleural cavity is entered. In removal of air-robbing, degenerated lung tissue, segmental resection back to normally bleeding bronchi is the aim. Clamp resection is no longer used for removal of the bullae. In our series of 70 cases, failure to resect far enough back on the bronchial tree has resulted in an 8% occurrence of bronchopleural fistula. It is essential that the flaps covering the stump or bronchi contain blood vessels (Brewer technique) to prevent this usually fatal complication in such pulmonary cripples. At times it is not possible to resect lung that is presently undergoing degenerative changes, as this would require a pneumonectomy that the patient could not tolerate, but it is important to remove as much destroyed lung as possible. The sympathetic chain is removed, including those ganglions, from the third thoracic vertebra to the diaphragm, that innervate the bronchial arterial system. The parietal pleura is removed, and the endothoracic fascia is severed to bring the remaining lung into direct contact with the chest wall and thus facilitate the ingrowth of nutrient systemic circulation. This ingrowth of new blood vessels is probably stimulated by the deficiency in oxygenation and by an added hormonal effect. The vagus nerve is severed according to Blades' technique, in an effort to lower the pulmonary artery pressure. The postoperative course of these patients is usually stormy, but in most cases this period is not prolonged. Such measures as improved bronchial drainage, maintenance of adequate airways, rapid reexpansion of the lung, control of upper respiratory tract infections, intermittent positive pressure breathing,[6] control of cardiac complications, and adherence to the principle of adrenal cortical influence on wound healing are of value in the postoperative management of the patient. In the main, patients who have come to surgery for degenerative lung disease have been respiratory cripples and medical failures; however, even in such cases, the results have been most gratifying, and many of these invalid patients have been able to return to full-time or part-time productive activity.

REPORT OF CASES

Case 1.—A 52-year-old white man was first seen by me in March, 1945. At that time his only complaint was dyspnea on exertion, which had progressed over a period of three years. There was no history of asthmatic attacks. Bronchoscopy and bronchograms showed essentially normal results. Because of his dyspnea, the patient moved to a drier climate. He was again seen by me six years later, in January, 1951, when his dyspnea had become so severe that he was unable to walk more than half a block without stopping to "catch his breath." He was hospitalized and placed on a medical regimen consisting of humidified oxygen, an expiratory resistance valve, antibiotics, bronchodilators, expectorants, and mercurial diuretics. With this regimen, the patient failed to show any marked improvement. On March 9, 1951, a thoracotomy was performed on the right side. When the pleural cavity was entered, complete degeneration of the apical and posterior segments of the upper lobe and

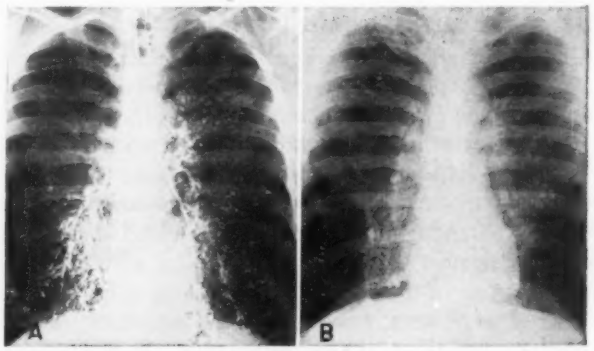

Fig. 2 (case 2).—*A*, bronchogram made Aug. 25, 1953, showing failure of the oil to penetrate into radiolucent areas in both lower lobes. *B*, roentgenogram made October, 1953, showing bilateral basilar areas of radiolucency well outlined by residual iodized oil.

6. Trimble, H. G., and Kieran, J.: Pulmonary Emphysema Treated by Intermittent Positive Pressure Breathing: A Clinical Study, J. Am. Geriatrics Soc. **2**: 102, 1954.

the superior segment of the lower lobe was found. The remainder of the right lung had undergone only slight degenerative changes. These bullous degenerated segments were removed, the vagus nerve severed, the sympathetic chain resected from the third to the ninth ganglion, and the parietal pleura removed from the chest wall area. The postoperative course was extremely stormy, but the patient was able to leave the hospital at the end of 10 days and was seen in my office on March 19, 1951. He was able to return to part-time activity six weeks after surgery and to full-time work at the end of two months. He has continued to work full time to the present, for three years, and he has been kept under a medical regimen of intermittent positive pressure breathing and control of upper respiratory infections. The Warring pulmonary function test done before surgery, on Jan. 18, 1951, showed a ventilation of 5.5 liters per minute with the patient walking and maximum breathing capacity of 11.8 liters per minute. The same test performed two years after surgery, on March 10, 1953, showed a ventilation of 11.8 with the patient walking and maximum breathing capacity of 32.1. This patient received sufficient clinical improvement from the surgery on the right side that he requested the same operation on the left; however, this has not been deemed necessary to date.

CASE 2.—A 33-year-old white man was admitted to the U. S. Naval Hospital, Oakland, Calif., on Aug. 14, 1953, because of abnormal findings on a routine 70 mm. photofluorographic roentgenogram of his chest. A 14 by 17 in. roentgenogram showed increased translucency at both bases. The patient gave a history of increasing exertional dyspnea for the preceding three years, associated with a cough productive of up to one cup of yellowish-green sputum a day. Physical examination was essentially normal except for decreased breath sounds bilaterally at both bases. Laboratory findings were normal, and bronchograms showed no evidence of bronchiectasis. On Oct. 28, 1953, a right thoracotomy was done, at which time degenerative lung disease was found to involve the entire right lung but was most marked in the posterior segment of the upper lobe and the superior and posterior basilar segments of the lower lobe. These segments were removed. A sympathectomy involving the third to the ninth ganglions was done as well as a vagotomy and parietal pleurectomy. The postoperative course was uneventful except that the patient stated he was able to breathe much better after surgery than before.

After a convalescence of two months, the patient underwent a left thoracotomy. At this time, degenerative lung disease was found, involving the entire left lower lobe and the lingula of the left upper lobe, which were removed. The remainder of the left lung was completely normal. A sympathectomy from the third to the ninth ganglion and a pleurectomy were performed, and the vagal fibers to the hilus were cut. The postoperative course was complicated by a bronchopleural fistula, and drainage of the chest was carried out on Feb. 11, 1954. Persistence of this fistula made repeated bronchoscopy necessary for the purpose of cauterization. The fistula was almost closed in April, 1954, leaving only a small tract, and the lung has expanded and become adherent to the chest wall around it. At present, more than three months after surgery, the patient is fully ambulatory but has not been returned to duty because of the slow closing of the bronchopleural fistula.

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TREATMENT OF NONTUBERCULOUS PULMONARY DISEASE

VIEWPOINT OF THE INTERNIST

Alvan L. Barach, M.D., New York

The management of nontuberculous diseases of the chest involves the application of a wide variety of basic sciences in such conditions as pulmonary emphysema, bronchial asthma, bronchiectasis, and chronic bronchitis. The aim of this presentation will be to discuss some of the disturbances in respiratory function commonly encountered in these clinical entities that lend themselves to physiologically directed therapy.

DISORDERED BREATHING PATTERN

Although it has long been understood that efficient aeration of the alveoli at bases of the lungs takes place through inspiratory contraction of the diaphragm, diaphragmatic breathing is frequently discarded in patients with bronchopulmonary diseases and an almost exclusively thoracic type of respiration adopted as a habit. In patients with pulmonary emphysema, paradoxical ascent of the diaphragm during inspiration may be observed when inflation of the upper chest is induced by contraction of the upper five intercostals, the shoulder girdle, and the accessory muscles in the neck; a serious and generally unnecessary impairment of diffusion of respiratory gases is then the result of rebreathing between the upper and lower lobes. Excessive use of the intercostal muscles and chest breathing has been observed in men with military training who have practiced an erect posture, with the shoulders back and the "guts sucked in"; in actresses who have been taught to manifest chest motion for its scenic effect a similar dominance of the intercostal muscles in ventilating the lungs may result in absence of diaphragmatic breathing. An additional sinister consequence of upper thoracic respiration is that the quantity of air admitted to alveoli at the bases of the lungs may be so small as to provide an inadequate force for expulsion of mucus even during vigorous coughing. Impairment of the mechanism of cough due to insufficient alveolar ventilation is a frequently unrecognized factor in the failure to expel retained secretions. The patient may eliminate the "overflow" of mucus in the upper respiratory tract and not plugs that occlude the smaller bronchi.

The use of measures to promote a more effective use of the diaphragm in patients with pulmonary diseases has long been advocated, including pneumoperitoneum and breathing and posture exercises.[1] An increased amount of air characteristically accumulates in the alveoli in patients with pulmonary emphysema, due in part to impairment of expiratory recoil of the lungs. Although the intrapleural pressure is negative during inspiration,

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Read in the Panel Discussion on Treatment of Nontuberculous Chest Diseases before the Section on Diseases of the Chest at the 103rd Annual Meeting of the American Medical Association, San Francisco, June 25, 1954.

1. (*a*) Hofbauer, L.: Atmungs-pathologie und therapie, Berlin, Germany, Julius Springer, 1921, p. 261. (*b*) Heckscher, H.: The Emphysema of the Lungs: Its Symptoms and Relations to Other Diseases, Acta med. scandinav. **120**: 349, 1945. (*c*) Gordon, B.: The Mechanism and Use of Abdominal Supports and the Treatment of Pulmonary Disease, Am. J. Sc. **187**: 692, 1934.

it may be found to be above that of the atmosphere during expiration as a result of contraction of the lower intercostal and abdominal muscles. Overinflation of the lungs is to a considerable extent maintained by check valve mechanisms that retard expiratory air flow in contracted bronchioles, especially during dyspnea and cough.[2] Although relief of bronchospasm by continuous bronchodilator aerosol therapy results in a twofold increase in expiratory flow rates, a decrease in the minute volume of breathing,[3] and a marked rise in maximal breathing capacity,[4] the clinical improvement thereby obtained does not restore diaphragmatic respiration but simply lessens the extent of costal, shoulder-girdle, and accessory neck muscle breathing.

Since a definitive program for the physiological training of the patient with pulmonary emphysema was initiated in the clinic of the Presbyterian Hospital.[5] I have seen several hundred patients in whom the increased capacity for exertion that resulted from the patient having learned some degree of diaphragmatic breathing confirmed the earlier clinical reports of the value of this approach. In the belief that the advocacy of diaphragmatic breathing programs would be strengthened by corroborative physiological evidence, quantitative data that mirrored the clinical improvement were sought. Measurement of the vital capacity and maximal breathing capacity, which portrays alterations in bronchial constriction so well, revealed little or no correlation with the pronounced clinical benefit of instituting diaphragmatic breathing. However, other measurements were obtained that showed that increased diaphragmatic movement in patients with pulmonary emphysema resulted in a more efficient diffusion of oxygen and carbon dioxide. A 20 to 30% lowering of the minute volume of breathing was produced by a headward tilt of the thorax, which in itself initiated a 4 to 5 cm. increase in diaphragmatic excursion. With the patient in a 20 degree head-down position, in which the weight of the abdominal viscera facilitates expiratory ascent of the diaphragm without contraction of the abdominal musculature, the arterial oxygen saturation and pH were found either unchanged or elevated and the arterial carbon dioxide unchanged or decreased.[6] Gas exchange of the lower lobes of the lungs was thus more efficient, since these results were obtained with a marked decrease in pulmonary ventilation, as compared to the relative dyspnea that accompanied costal respiration in the erect posture.

When patients assume a bending-forward position, the visceral pull on the diaphragm is also decreased and the elastic recoil of the lungs aided, with a similar although less marked relief of dyspnea and lowering of the total pulmonary ventilation. With the additional use of the G. B. emphysema belt, by which a higher position of the diaphragm is maintained, a more marked lowering of the minute volume of breathing may be produced in patients with emphysema in whom diaphragmatic breathing has been substituted for costal and accessory neck muscle respiration. Training in breathing exercises, including especially the use of the head-down and the bending-forward positions, gradually enables the patient to increase the degree of diaphragmatic movement in the standing and walking positions and in that way favorably modifies dyspnea on exertion. Active contraction of the abdominal muscles during expiration, originally suggested by Hofbauer [1a] to aid recoil of the lungs is less effective than the methods described above.[6a]

RETENTION OF MUCOID AND PURULENT SECRETIONS IN THE LUNGS

Since inadequate elimination of bronchial secretions promotes dyspnea as well as infection, studies of the mechanism of human coughing have included such factors as obstructing the flow of air into functioning alveoli, loss of muscle substance in the bronchial wall, deficient ciliary action, decreased pulmonary elasticity, and expiratory check valve mechanisms that retard the exit of inspired air from the alveoli and promote bronchial occlusion. The relative increase in intra-alveolar over intrabronchial pressure produced in the cough of patients with pulmonary emphysema and allied diseases results in premature bronchial collapse.[2] In these patients a cough of moderate effort after a deep inspiration appears to be more effective than one of excessive force, which may result in bronchial closure. Manual compression of the lower thorax and upper abdomen has been used to facilitate expectoration and reduce alveolar distention, especially after bronchospasm has been relieved by inhalation of bronchodilator aerosols. The aerosol treatment of bronchospasm may be carried out with a hand bulb nebulizer; continuous nebulization of dilute bronchodilator solutions may be accomplished by air pumps, oxygen from a cylinder, and intermittent pressure breathing devices. Bronchospasm, characteristic of bronchial asthma and the bronchospastic type of pulmonary emphysema, also occurs in chronic bronchitis and in some cases of bronchiectasis. Maintaining the patient in a state responsive to bronchodilator medication is done with the various techniques of remissive therapy. Recurring refractoriness to bronchodilator medication, frequently a difficult problem, manifestly plays a role in the retention of mucopurulent secretions in the lungs. Postural drainage has long been known as an effective method of treatment in patients with retained pulmonary secretions; however, the use of the supine position, with the thorax tilted headward at an angle of 16 to 22 degrees, is often of more practical value when practiced for an hour or more three times a day and at times at night.

The therapeutic use of mechanically induced "cough" has been recently introduced as a new principle of bronchial drainage; exsufflation with negative pressure, the term used to describe a system of positive and negative pressure breathing in which a gradual inspiratory inflation of the lungs is followed by abrupt deflation, is the

2. Dayman, H. G.: Mechanics of Air Flow in Health and Emphysema, J. Clin. Invest. **30**: 1175, 1951. Proctor, D. F.; Hardy, J. B., and McLean, R.: Studies on Respiratory Air Flow: Observations on Patients with Pulmonary Disease, Bull. Johns Hopkins Hosp. **87**: 225, 1950.

3. Barach, A. L.: Physiological Methods in the Diagnosis and Treatment of Asthma and Emphysema, Ann. Int. Med. **12**: 454, 1938.

4. Richards, D. W., Jr.; Barach, A. L., and Cromwell, H. A.: Use of Vaporized Bronchodilator Solutions in Asthma and Emphysema: A Continuous Inhalation Method for Severe Asthmatic States, Am. J. M. Sc. **199**: 225, 1940.

5. Barach, A. L.: Advances in the Treatment of Diseases of the Chest, Cincinnati J. Med. **30**: 131, 1949.

6. Barach, A. L., and Beck, G. J.: The Ventilatory Effects of the Head-Down Position in Pulmonary Emphysema, Am. J. Med. **26**: 55, 1954.

6a. Barach.[5] Barach and Beck.[6]

most effective of the methods employed.[7] The swift opening of a high speed valve results in a total pressure drop in the mask or mouthpiece of 60 to 80 mm. Hg in 0.02 second. Inflation of previously unventilated alveoli and the high velocity of air leaving the lungs are the chief factors responsible for the blowing of mucus from the smaller bronchi into the upper respiratory tract. The employment of exsufflation with negative pressure is of therapeutic value in patients with pulmonary atelectasis due to a variety of causes and may be of crucial benefit in bronchopulmonary disease in which adequate bronchial drainage is not achieved because of an impaired cough mechanism, frequently characteristic of patients with emphysema and bronchiectasis. The management of chronic pulmonary infection appears to have a new prospect of control by the joint use of mechanically induced methods of bronchial drainage and appropriate antibiotic treatment. Reports from other clinics have confirmed the value of eliminating retained secretions from the lungs by the use of exsufflation in poliomyelitis,[8] pulmonary emphysema, lung abscess, and postoperative states.[9] The apparatus employed is used with a mask or a mouthpiece with a metal insert; a separate plastic tube for inspiration and expiration, with a filter on the inspiratory tube, has materially simplified the sterilization of the apparatus.

IMPAIRMENT IN DIFFUSION OF OXYGEN AND CARBON DIOXIDE

Although attempts to improve respiratory function in patients with chronic diseases of the chest now make use of measures in addition to the administration of therapeutic gases, the treatment of hypoxia and carbon dioxide retention frequently requires the expert employment of inhalation therapy. An increasing concern over the development of respiratory acidosis after administration of high concentrations of oxygen to patients with bullous pulmonary emphysema has at times resulted in an unwarranted deprivation of all oxygen therapy. A controlled dosage of oxygen inhalation is generally indicated for the treatment of acute exacerbations of hypoxia in chronic respiratory disease and in patients with pulmonary emphysema and cor pulmonale. Since a damaged respiratory center should not be left deprived of the agent that is most apt to insure its recovery, namely, oxygen, continuous, not intermittent, oxygen therapy is indicated for patients whose dyspnea is of hypoxic origin. Oxygen is administered by double-bent nasal tubes or a nasal catheter, beginning with flows of one to two liters per minute [8]; with a gradual increase in the rate of oxygen administration, chlorides are eliminated and bicarbonate is retained to maintain a homeostatic equilibrium; a high partial pressure of carbon dioxide buffered by base in the arterial blood constitutes a mechanism that in itself facilitates the elimination of the carbon dioxide in high concentration in the expired air.[10] Respiratory acidosis may usually be avoided by this program; in severe cases, in which acidosis is frequently present prior to oxygen treatment, increasing the pulmonary ventilation by mechanical methods is used to blow off carbon dioxide.[11] Augmenting the pulmonary ventilation of the patient by physical means is best achieved by intermittent pressure breathing devices other than the tank respirator, which at times permits the patient to breathe against the cycle of the respirator, unless the exsufflator attachment to the respirator is used.[12] Exsufflation with negative pressure is an effective method of blowing off carbon dioxide and may be readily repeated at one to two hour intervals to combat respiratory acidosis; the use of the latter device also promotes a free respiratory passageway by eliminating mucus in the smaller bronchi; it thereby additionally aids the diffusion of both oxygen and carbon dioxide.

INADEQUATE MUSCULAR AND MENTAL EXERTION

Physical exercise to the point of dyspnea has long been known to produce trapping of air within the lungs and progressive alveolar distention in patients with pulmonary emphysema and allied respiratory disorders; as a result of check valve mechanisms previously referred to, the retarded expiratory air flow does not permit a high pulmonary ventilation except at the cost of progressive overinflation of the lungs. Hyperventilation, even as a manifestation of psychosomatic disease, contributes to perpetuation of dyspnea by distending diseased alveoli. The results of lack of exercise, however, include a lack of muscle tone as well as inadequate outlets for the natural craving for excitement. The value of muscular exercise in patients with bronchial asthma has been emphasized by Schutz,[13] who has called attention to the observations of Selye [14] on the therapeutic effect of muscular exercise, especially its stimulating effect on the adrenal cortex. Since the training program used for athletes results in increased capacity for exercise without increase in vital capacity and in some way aids the use of oxygen, a program of exercise during the inhalation of oxygen was carried out in our clinic through use of the double-bent nasal tube with an oxygen flow at the rate of 8 to 10 liters per minute; during the inhalation of oxygen-enriched air mixtures, exercise was possible in patients with pulmonary emphysema and allied disorders, with surprisingly little dyspnea and with minimal trapping of air within the lungs.[7] Under this regimen the favorable effects of muscular exercise were manifested during the development of the training program, i. e., an increased capacity for walking, with less dyspnea and less increase in pulse rate after exercise than had been previously observed.

An increase in capacity for exercise on exertion may lead the way to encouragement of the patient to adventure forth into those fields of life that may precipitate what Seyle [14] has called "therapeutically optimal alarm-

7. Barach, A. L., and Beck, G. J.: Exsufflation with Negative Pressure: Physiological and Clinical Studies in Poliomyelitis, Bronchial Asthma, Pulmonary Emphysema and Bronchiectasis, A. M. A. Arch. Int. Med. **93**: 825 (June) 1954.

8. Affeldt, J. E.: Recent Advances in the Treatment of Poliomyelitis, J. A. M. A. **156**: 12 (Sept. 4) 1954.

9. Williams, E., and Halliday, D.: To be published.

10. Richards, D. W., Jr., and Barach, A. L.: Prolonged Residence in High Oxygen Atmosphere: Effects on Normal Individuals and on Patients with Chronic Cardiac and Pulmonary Insufficiency, Quart. J. Med. **3**: 437, 1934. Barach.[5]

11. Motley, H. L.; Werkö, L.; Cournand, A., and Richards, D. W., Jr.: Observations on the Clinical Use of Intermittent Positive Pressure, J. Aviation Med. **18**: 417, 1947.

12. Cherniack, R. M.: The Effect of Mechanical Exsufflation of Respiratory Gas Exchange in Chronic Pulmonary Emphysema, J. Clin. Invest. **32**: 1192, 1953.

13. Schutz, K.: Exercise in Bronchial Asthma, New York J. Med., to be published.

14. Selye, H.: The General Adaption Syndrome and the Diseases of Adaption, J. Clin. Endocrinol. **6**: 117, 1946.

ing stimuli"; an enterprise of this kind obviously requires as much emotional maturity as the person is capable of. In the experiments of Richter,[15] quoted in this connection by Schutz,[13] the adrenal glands of the domesticated Norway rat, compared with those of the wild rat, were found to have undergone a marked atrophy during the process of domestication and presumably were less able to protect the animal against hazard and stress. The statement of Marlow, "Oft have I surmised and finally have I learned that Peril is the chiefest way to happiness," may be especially pertinent to the patient with bronchospastic disease. Perhaps the speculation is justified that a too "pastoral" life may lead to a pathophysiological deficiency state of the adrenal glands, which poorly equips the bronchospastic patient for his constitutional disease. In any event, an undue degree of rest and a prohibitive attitude toward mental excitement has seemed to me to be of less value to the patient with asthmatic dyspnea than a program that allows as full a participation as possible in such stimulating activities as our society affords.

SUMMARY

Some of the major disturbances of respiratory function in patients with nontuberculous chest diseases are: (1) disordered breathing patterns, (2) retention of pulmonary secretions, (3) impaired diffusion of oxygen and carbon dioxide, and (4) inadequate muscular and mental exertion. The therapeutic measures to counteract these disturbances in respiratory function include training in diaphragmatic breathing; efficient methods in bronchial drainage, including exsufflation with negative pressure and the head-down position; the inhalation of oxygen in hypoxic states and intermittent pressure breathing; muscular exercise during the inhalation of oxygen in a special training program; and, finally, avoidance of regimens of a more "pastoral" nature than is necessary.

ADDENDUM

Since this paper was written studies on exsufflation with negative pressure have revealed sharp differences in the effect of this procedure on the various clinical entities in which it has been used. In cases of respiratory paralysis the movement of mucopurulent sputum from the small bronchi to the mouth is readily accomplished in almost all instances. In bronchiectasis the elimination of retained pulmonary secretions is accomplished during and after the procedure. Coughing, provoked when the sputum arrives at the upper respiratory tract, is frequently productive of previously retained secretions.

In the group of cases characterized by bronchospasm, i. e., bronchial asthma and pulmonary emphysema, an effective result requires a more careful attention to technique and patient cooperation. The prior employment of bronchodilator aerosols to widen the diameter of constricted bronchi and a passive inflation of the lungs are necessary, since voluntary inspiration may impair the efficiency of the subsequent high expiratory flow rate. In addition, any conscious effort to aid exsufflation by coughing during the expiratory cycle is a handicap, since the increase of intrapulmonary pressure may result in bronchial closure similar to that induced by the patient's own coughing. Therefore, any tensing of the respiratory musculature is a disadvantage in these cases both during inspiration and expiration.

Use of exsufflation with negative pressure is indicated in bronchopulmonary disease when retained secretions definitely impair respiratory function. The physiological effect of exsufflation with negative pressure is to deliver mucus or pus from the smaller bronchi to the region of the tracheobronchial bifurcation. A cough of moderate effort may then result in an expectoration of secretions that the patient previously had been unable to move.

15. Richter, G. P.: The Effect of Domestication on the Steroids of Animals and Man, Abstract. Science **114**: 486, 1951.

THE PATTERN OF PAIN IN THE DIAGNOSIS OF UPPER ABDOMINAL DISORDERS

Lucian A. Smith, M.D., Rochester, Minn.

In their respective ways both the stoic and the neurotic tend to obscure the true pattern of their pain and to hinder the physician in evaluating it. The stoic may lack ability to describe pain or even to feel it adequately. The neurotic patient with a low threshold to discomfort, on the other hand, may give too many details and thereby conceal an otherwise adequate pattern of pain. Other factors, including the nature of the lesion, its size, depth, and acuteness; the location of the organ involved; the type and extent of the stimuli provided by the lesion; and the nerve pathways that are involved, also affect the production of such patterns of pain and, in turn, the physician's evaluation of the pain. Stimulation adequate to produce pain naturally includes distention and spasm in the case of hollow viscera and acid, enzymatic, infiltrative, and bacterial stimuli in the case of the peritoneal surfaces. In addition, torsion, traction, and friction may be involved in the production of peritoneal pain. An ulcerating lesion may produce its peritoneal pain by perforation, either free or localized, and the ulceration that is in contact with hydrochloric acid may produce pain even though the peritoneum is not involved. Penetration and obstruction are common sources of pain in lesions involving hollow viscera.

It is not always easy to differentiate visceral from somatic pain. As a rule, visceral abdominal pain occurs

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Figures 1, 2, 5, 6, 7, 8, 10, and 11 in this report are reprinted from Smith, L. A., and Rivers, A. B.: Peptic Ulcer: Pain Patterns, Diagnosis and Medical Treatment, New York, Appleton-Century-Crofts, Inc., 1953.

Read in the Symposium on Pain: Causative Mechanisms, Effects, and Therapy, before the Joint Meeting of the Section on Anesthesiology, the Section on General Practice, and the Section on Military Medicine at the 103rd Annual Meeting of the American Medical Association, San Francisco, June 25, 1954.

in the midline of the abdomen and is symmetrical in its location (fig. 1). It tends to be fluctuating and to cause restlessness, nausea, vomiting, crampy gnawing sensations, and sweating. The patient may wish to double over, and he attempts to relieve the pain by change of position. Ureteral colic has a tendency to lateralize and is therefore an exception to the rule that visceral pain tends to appear in the midline. The site of the visceral or splanchnic type of pain is of some service in determining the approximate location of the lesion in the longitudinal axis of the trunk, even though it is of little

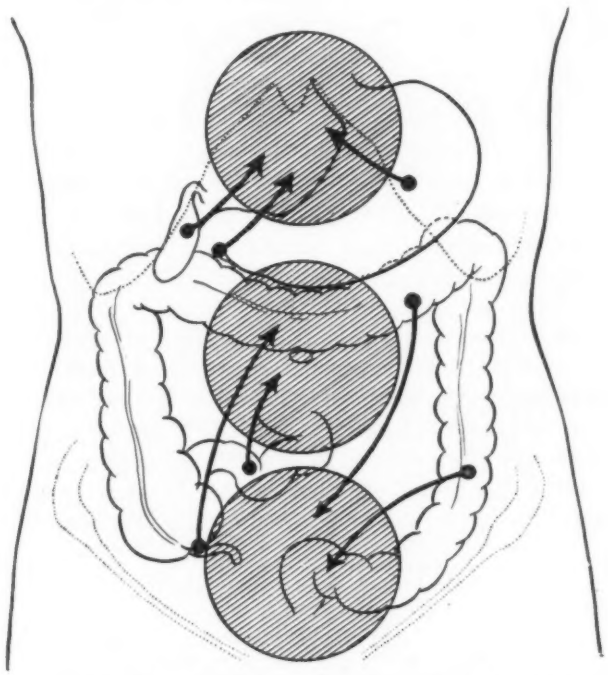

Fig. 1.—Splanchnic pain of lesions in hollow abdominal viscera tends to be referred to the midline. Black dots indicate lesions.

help in lateralization of the lesion. Somatic pain resulting from involvement of cerebrospinal nerves is of great value in placing the exact location of the lesion (fig. 2). However, pain of this type may not appear until localized perforation or infiltration from the viscus is advanced. Its quality is different from that of visceral pain, since it tends to be steady rather than fluctuating, and it may be described as boring or knife-like. It leads to splinting of the trunk, and it is aggravated by bending, jarring, walking, or riding. Somatic pain occurs when the rebound test is used. The patient's account of pain should be analyzed by the physician in an attempt to follow the course of both the visceral and the somatic components. When a duodenal ulcer develops a tendency to penetrate, for example, the story changes from the usual account of uncomplicated ulcer. Whenever the ulcer becomes deep enough to involve the serosa and the parietal peritoneum is irritated, the shift of pain that occurs may not only indicate that perforation is impending but also indicate the exact site. The shift of pain to the right from a midline infraxiphoid location may point to the duodenum or the gallbladder as the source, while a shift to the left may indicate that the stomach or the tail of the pancreas is the source.

The mechanisms by which the patterns of pain form themselves should be mentioned, since the interpretation of the infinite variation of patterns is dependent on the information of the examining physician. The splanchnic pathways (fig. 3) are involved through the stimulation of the plexuses of Meissner and Auerbach, and the nerve impulses are transmitted through the splanchnic fibers that pass uninterruptedly through the celiac ganglions, the sympathetic trunk and the rami communicantes to the splanchnic cell bodies in the dorsal root ganglions to terminate centrally in the lateral portion of the spinal cord. The cerebrospinal nerve endings are thought to be in the parietal peritoneum, the mesentery, and the lesser omentum within 1 or 2 cm. of the free border of the viscus. Adequate stimulation of these nerve endings sends impulses by way of the segmental cerebrospinal nerves to the ordinary sensory ganglions in the dorsal root and from there centrally to the lateral portion of the spinal cord. These stimuli can be located accurately in the sensorium and constitute a direct method of locating the lesion that produces them. Five patterns of pain are produced by peptic ulcer, and the same patterns can be noted and interpreted in the presence of gallbladder disease.

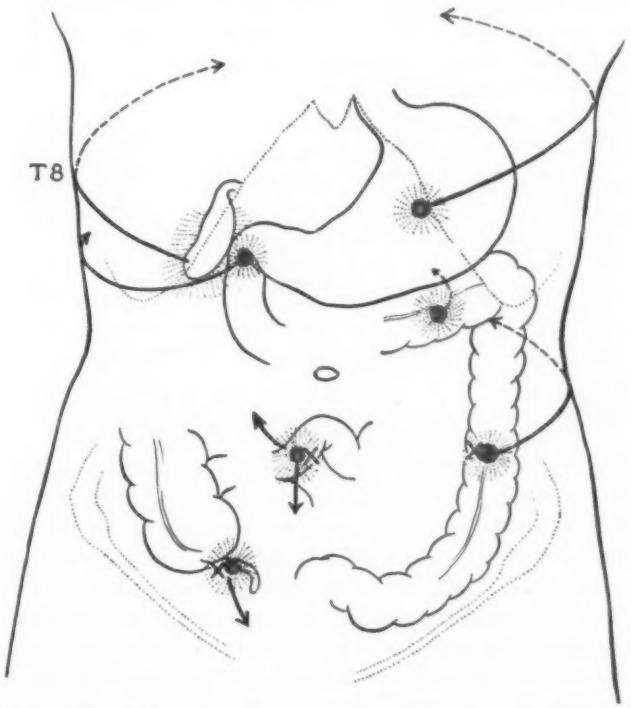

Fig. 2.—Projection of pain of perforating lesions of hollow abdominal viscera. Black dots indicate lesions. Arrows indicate extension of pain.

THE FIVE PATTERNS OF PAIN

1. Visceral Pain Alone.—A lesion such as the uncomplicated, shallow duodenal ulcer usually produces the pain that is referred to as "typical ulcer pain." This pain, which is located in the midline of the epigastrium below the xiphoid process of the sternum, is symmetrical (fig. 4), and while it may be in a small region the location is nonspecific, since it can be duplicated by pain from lesions in other organs. Chronic cholecystitis with stones, for example, may lead to the production of

colic-like distress that is comparably in the midline of the epigastrium and may resemble the distress of pylorospasm. It may even produce a pattern of distress that resembles the rest of the ulcer story, including pain at night and relief after taking of alkalies. This visceral type of pain is obviously of little value in determining in which side of the trunk the affected organ lies.

2. Summation Pain.—When the peptic ulcer involving only the wall of the duodenum begins to penetrate, spasm and acid stimuli are added to each other to produce a shift of the pain toward the right from the midline whenever the pain is at its maximum. In a similar fashion, gallbladder colic, which may have been in the midline of the epigastrium below the xiphoid process of the sternum at its onset, may shift to the right at the peak of the pain, reaching the right costal margin or perhaps even the classical site in the right subscapular region. This pain really seems to be a spilling over of maximal stimuli that are first transmitted by the splanchnic nerves to the cord and then interpreted by the patient through the corresponding segmental cerebrospinal nerve. The shift of pain that occurs during such spillage is of great value in indicating on which side of the trunk the involved organ lies.

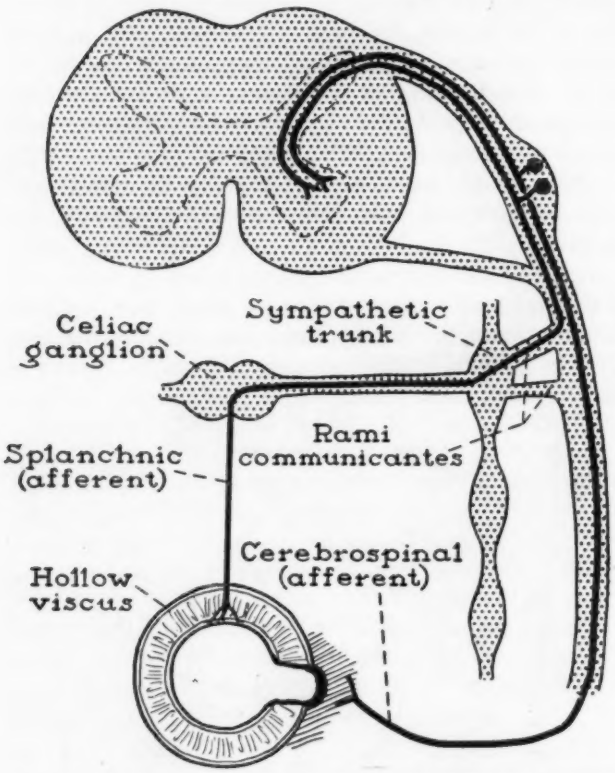

Fig. 3.—Diagram of afferent splanchnic and cerebrospinal sensory pathways.

3. Visceral and Somatic Pain Mixed.—When a penetrating duodenal ulcer deepens enough to involve the serosa, the adjacent parietal peritoneal surfaces may be involved. When this occurs, a steady somatic component may be added to the fluctuating visceral type of pain so characteristic of ulcer. The pain pattern that results will include both visceral and somatic components. The somatic portion may consist of a shift of the pain to the right and the addition of pain in the right subscapular region or the interscapular region, or the pain may be referred to the back in a manner typical of pancreatic involvement. Similarly, after severe gallbladder colic that is transmitted by the splanchnic nerves, residual soreness, usually localized over the gallbladder and resulting from serosal and parietal peritoneal irritation, may develop. If the inflammatory process involves the fundus of the gallbladder, the residual tenderness is mostly below the costal margin and is accompanied by pain on bending or during the use of a tight belt. If most of the peritoneal irritation is in the lesser omentum adjacent to a stone impacted in the cystic duct, tenderness may be localized deep in the lesser omental region and the somatic pain may be felt chiefly in the interscapular region. The difference may result because the fundus is not inflamed even though distended and because the periductal tissue is inflamed and edematous even though not distended.

4. Somatic Pain Alone.—This pattern of pain is interesting and important because it is responsible for bizarre syndromes in which the original visceral pain has been lost or in which the somatic pain so overshadows the visceral pain that the latter is ignored by the patient. It may be produced by a large perforating ulcer that gives pain so far lateral to the old visceral pain that the patient may mislead the examining physicians into thinking that it is totally dissimilar to the old pain that he had experienced with the ulcer. In some cases it is confused with perforating disease of the gallbladder, and in the left side of the abdomen it may be confused with carcinoma of the tail of the pancreas or even with the nocturnal pain of cord tumor. A comparably deceptive situation exists when a patient with a chronically impacted stone in the cystic duct is aware of pain only in the interscapular region and denies the presence of pain in the abdomen.

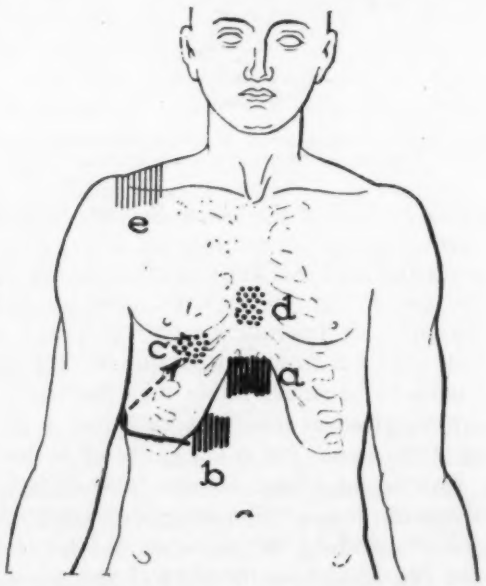

Fig. 4.—Common sites of pain in cases of duodenal ulcer. *a*, original visceral pain. *b*, summation pain. *c*, extension to subscapula in summation pain or pain of mixed visceral and somatic origin. *d*, interscapular somatic pain in involvement of lesser omental tissues. *e*, rare, special phrenic pain with referral to the right.

5. Phrenic Pain.—The pain transmitted by phrenic fibers actually is a somatic type of pain, but it involves a special pathway and, therefore, is considered separately. The left phrenic nerve, originating in the third, fourth, and fifth cervical nerve roots, supplies sensory fibers to the ventral surface of the dome of the left hemidiaphragm. When these fibers are involved by perforating ulcer of the gastric fundus, either benign or malignant, or by a subdiaphragmatic abscess the pain may be interpreted by the patient as occurring in the left supraclavicular region and occasionally as spreading from there to the left arm, being referred through the brachial plexus. The right phrenic nerve similarly supplies the central dome of the right hemidiaphragm, its ventral surface, and the capsule of the liver, and in about 5% of persons fibers can be traced to the lesser omental area. An ulcer perforating to the lesser omental

Diagnoses Suggested by Certain Pain Patterns and Certain Locations of Pain Referable to Body Segments

Location of Pain or Shift	Body Segment	Diagnosis
Upward shift	T5-T6	Diaphragmatic hernia; gastric ulcer; esophageal ulcer
Epigastrium	T6-T10	Diaphragmatic hernia; gastric ulcer; duodenal ulcer; gallbladder disease; pancreatic lesions; esophageal lesions; angina; carcinoma of cecum
Interscapular region	T6	Lesser omental involvement by gastric ulcer; cystic duct stone; perforating duodenal ulcer; esophagitis
Left shift	T6-T8	Gastric ulcer; lesion in tail of pancreas; pyloric obstruction from duodenal ulcer or carcinoma; gallbladder disease (rare)
Right shift	T8	Duodenal ulcer; gallbladder disease; pancreatic involvement; prepyloric gastric ulcer (rare)
Subscapular region	Right or left	Right: duodenal ulcer; gallbladder disease; involvement of head of pancreas
	T8	Left: gastric ulcer; lesion of tail of pancreas; perforating carcinoma of colon; gallbladder disease (rare)
Pancreatic region	T10-L2	Pancreatic lesions
Downward shift; mesocolon, renal, or splenic involvement	T10-L1	Shift to right lower quadrant, testis, or thigh: duodenal ulcer Shift to lower part of abdomen: gastric ulcer; splenic lesion; gastrojejunal ulcer; jejunal ulcer
Supraclavicular region	Right or left	Right: gallbladder disease; subdiaphragmatic abscess; duodenal ulcer (rare); amebic liver abscess Left: involvement of dome of left hemidiaphragm by diaphragmatic hernia or by perforating gastric ulcer; left subdiaphragmatic abscess; high anastomotic ulcer

tissues or the edema surrounding a stone impacted in the cystic duct may give rise to somatic pain that is interpreted by the patient as being in the right supraclavicular region or even as extending from there into the right arm.

PAIN AS A TOOL IN DIAGNOSIS

The visceral pain from lesions in the upper part of the abdomen is illustrated diagrammatically by the uppermost circle in figure 1. In actuality the visceral pain may center slightly to the side of the midline on which the abdominal disease lies. However, it is usually so poorly localized that it is necessary to illustrate it as being placed centrally. When the lesion giving rise to the pain perforates enough to stimulate the somatic or cerebrospinal pathways, the pain is detected accurately in the corresponding segmental dermatomes.

Some clue may be obtained as to the nature and location of the lesion by the shift of the pain or by its location according to dermatomes. Reference to the table, for example, shows that a lesion perforating to the lesser omentum may give rise to its somatic pain in the interscapular region but that pain from a lesion above the diaphragm, as from esophagitis, also may be felt in this region. In the differential diagnosis of interscapular pain one would also have to consider perforating duodenal ulcer and stone impacted in the cystic duct. The orthopedist who might see a patient with such pain

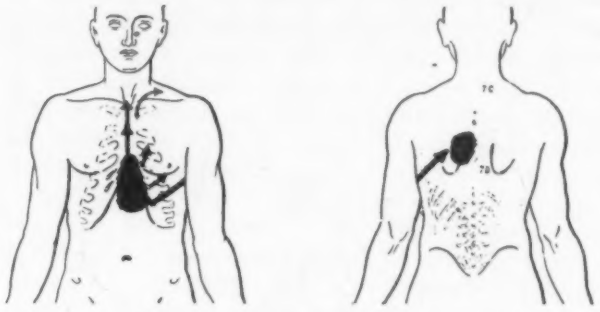

Fig. 5.—Site of pain in a case of gastric ulcer associated with diaphragmatic hernia.

must recognize these possibilities in addition to the possible causes in the thoracic portion of the spinal column. A consideration of the pain patterns of individual lesions in the upper part of the abdomen will often provide a clue that leads to the correct diagnosis. Dependence on roentgenologic and laboratory methods alone for diagnosis may prevent arriving at the correct conclusion.

Diaphragmatic Hernia.—Recent studies have shown that diaphragmatic hernia is a common condition and that it has often been overlooked in the past because of misinterpretation of the symptoms as being on a functional basis. The distress at first may be in the midline of the epigastrium, below or behind the xiphoid process (fig. 5). It may be interpreted by the patient as being of ulcer type, and there may or may not be dysphagia to indicate the high location of the disorder. Bleeding may occur when ulceration is present, but commonly the ulceration is too shallow to provide so-

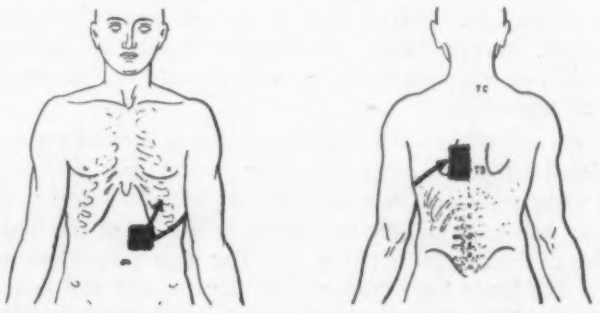

Fig. 6.—Site of pain in a case of ulcer of the lesser curvature of the stomach.

matic cerebrospinal stimulation, so that again the high location of the disorder is not recognized. In fact, the bleeding may be so silent and insidious that it produces obscure anemia. While distress is still visceral, the upper epigastric distress may be noted only at night and may occur soon after the patient goes to bed. The aggravation of the distress in the supine position may be accompanied by relief of the distress when the patient sits,

stands, or walks. If, in addition, the distress is referred up the esophagus to the throat, perhaps even with regurgitation, diaphragmatic hernia may be suspected. This is even more likely as a possibility if the patient is obese and more than 50 years of age.

If ulceration is present and giving rise to frequent symptoms, it also may deepen itself sufficiently to give referral of the pain into the somatic pathways, usually

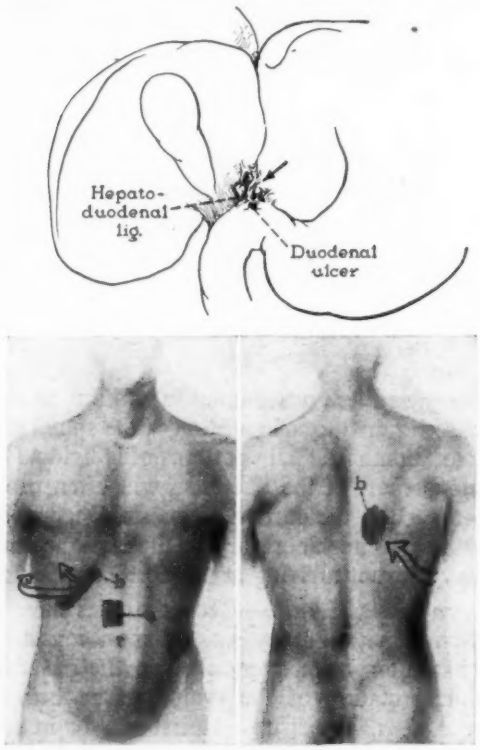

Fig. 7.—Site of pain of duodenal ulcer perforating to lesser omental structures (hepatoduodenal ligament). *a*, initial pain. *b*, secondary extension.

the left fifth or sixth thoracic segments with referral into the left side of the chest in the region of the left breast; if the dome of the left half of the diaphragm is involved pain may be referred also to the left supraclavicular region. The positional relationship and the referral as a shift of the pain to the left and upward are the chief characteristics.

Gastric Ulcer.—Because the stomach is closely associated with many other structures, gastric ulcer may give a wide variety of pain patterns. Its initial visceral pain may be in the midline or slightly to the left of the midline of the epigastrium (fig. 6). The high gastric lesions on the lesser curvature or the benign and malignant ulcers of the fundus commonly give somatic pain with a shift to the left and upward into the chest or into the left subscapular region or interscapular region. Most gastric ulcers occur just posterior to the lesser curvature of the stomach, and they may involve the lesser omentum or the lesser omental sac as soon as perforating tendencies develop. Such a development may be expected to give a shift of the pain to the left and upward or to the interscapular region; the level of the referred pain may correspond to the body segment of the perforation. The pancreas is commonly involved by perforations of the lesser curvature, the posterior wall, and even the greater curvature. With these, the back pain of pancreatic involvement may be added. This is felt by the patient at a lower level than the interscapular region, usually the 10th thoracic to the 2nd lumbar segments of the back. Depending on the site of the perforation, this back pain may be greater on the left side.

Perforating ulcers on the greater curvature of the stomach are more commonly malignant than benign. They may involve the peritoneum in the region of the spleen sufficiently to give rise to pain in the lower part of the abdomen, in the 12th thoracic segment. The same type of lesion on the greater curvature may also involve the mesocolon, which receives its somatic nerves from the lowest thoracic segments and, hence, refers such pain to the lower part of the abdomen. The perforating lesion of the greater curvature of the stomach that involves the mesocolon also may tend to perforate the colon and in doing so may give rise to pain low in the abdomen and an irritable colon syndrome prior to development of a gastrocolic fistula.

Prepyloric gastric lesions may involve the pancreas and give rise to back pain and also may involve the lesser omentum and cause pain between the scapulas; in the immediately preplyoric region the pain sometimes

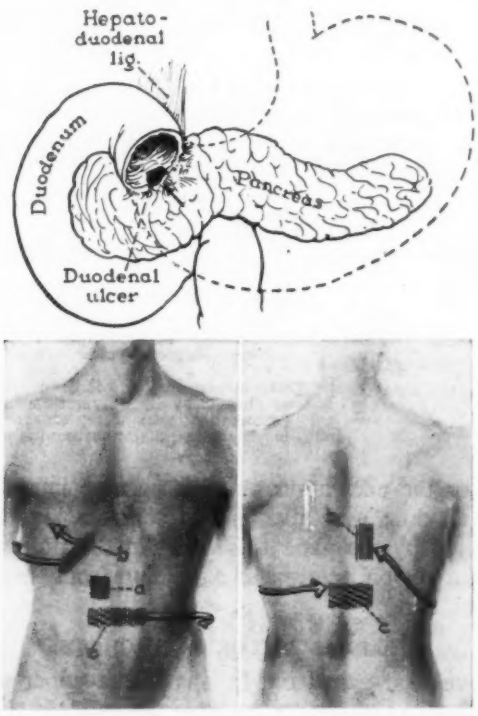

Fig. 8.—Site of pain of duodenal ulcer perforating to pancreas and hepatoduodenal ligament. *a*, original pain. *b*, extension of pain indicating invasion of lesser omental structures. *c*, pain indicating invasion of pancreas.

shifts toward the right. Such lesions, through spasm or neoplastic growth, may give rise to early obstruction, which may additionally give the usual shift to the left and upward. The left phrenic nerve pathway may be involved, giving rise to left supraclavicular pain, when high ulceration, either benign or malignant, involves the dome of the diaphragm. If the lesion is extensive there may be pain low in the left lateral and posterior parts

of the chest, since the peripheral portions of the hemidiaphragm are innervated by the nerves from lower thoracic segments. If perforation leads to the formation of a left subdiaphragmatic abscess either by local perforation or by distant leakage into the lesser omental sac, similar somatic pain patterns may occur.

Duodenal Ulcer.—The initial midline epigastric pain of duodenal ulcer (fig. 7) commonly shifts to the right when penetration or localized perforation occurs. When

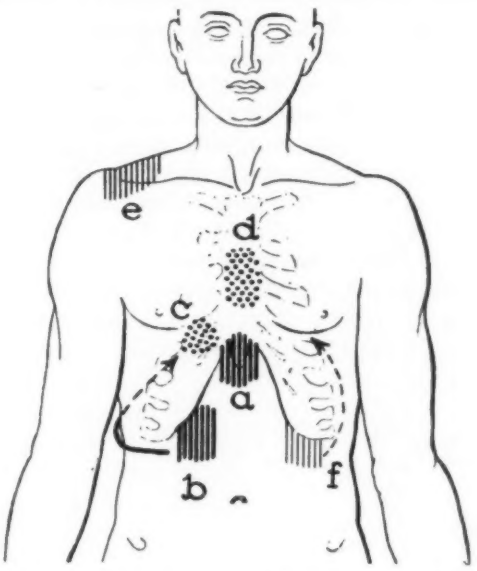

Fig. 9.—Sites of pain that may occur in a case of cholecystitis with stones. *a*, visceral pain alone. *b*, summation pain. *c*, subscapular pain of summation or of mixed visceral and somatic origin. *d*, interscapular somatic pain alone. *e*, special right phrenic referral of pain. *f*, uncommon left-sided pain.

the perforation is on the right posterolateral wall, the lesser omental tissues may be involved. The referral of pain to the interscapular region combined with the right shift of the pain may confuse the picture with that of gallbladder disease. If the perforating ulcer is on the right lateral wall of the duodenum and the perforation involves the nearby perirenal tissues and the base of the mesocolon, referral of the somatic type of pain to the right lower quadrant of the abdomen may give enough of the picture of acute appendicitis to cause the removal of a normal appendix. Difference in the quality of the pain usually distinguishes it from the visceral pain of right ureteral colic. If the perforation involves the base of the gallbladder, distinguishing the pain pattern from that of gallbladder disease may be impossible clinically.

An ulcer perforating the posterior wall of the duodenum may give rise to the usual pain of pancreatic involvement (fig. 8) from the 10th thoracic to the 2nd lumbar segments, perhaps greater on the right than on the left. The occurrence at night and the mode of relief of this pain by pressure or attempts at positional relief by sitting doubled over may help to confirm the diagnosis of focal pancreatic involvement, although it may be difficult at times to distinguish this from the pain of carcinoma of the pancreas. If the duodenal ulcer that has been identified as such by the location of its visceral pain and perhaps by the shift of pain to the right during subacute perforation later causes obstruction of the pylorus, there may be an additional shift of distress to the left and upward. This may result from the obstruction or, in some instances, from an associated gastric ulcer.

Perforating ulcer of the anterior wall of the duodenum may give visceral pain initially followed by the development of somatic pain localized anteriorly. As the serosa is involved and the parietal peritoneum is irritated, localized tenderness without shift or referral to the back may lead one to suspect impending anterior perforation. If perforation actually occurs, it is apt to be free, since adjacent structures are limited in their ability to ward off perforation. This is especially true if the greater omentum is inadequate in size. If the greater omentum is adequate in size, it may interfere with the correct diagnosis, since it separates the lesion from the sensitive anterior parietal peritoneum. The greater omentum does not have cerebrospinal nerves, hence it may prevent the development of localized tenderness.

Gallbladder Disease.—Chronic cholecystitis with stones may give rise to no symptoms, or it may duplicate the symptoms of many of the other disorders in the upper abdominal viscera (fig. 9). If the initial distress is in the midline of the epigastrium, the dyspepsia at times will suggest peptic ulcer. This resemblance may be complete with nocturnal pain and fairly characteristic relief following the use of alkalies. If the visceral pain becomes severer in that same region, it may be felt as a colic that duplicates the pain of gastrospasm or pylorospasm, and it may remain in the midline. More commonly, as the visceral pain becomes severer the pain shifts to the right and is felt in the right upper quadrant or, in its severer forms, in the right subscapular region in the eighth thoracic dermatome. If there is pericholecystitis, the peritoneal involvement is felt as a residual soreness that may be indistinguishable from the inflam-

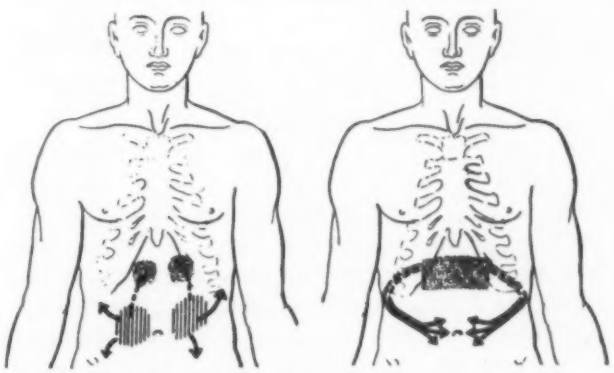

Fig. 10.—Left, site of pain of pancreatitis. Right, back pain and engirdling pain of pancreatitis.

matory reaction about a duodenal ulcer perforating in that region. The clue may lie in the fact that such soreness usually follows an attack.

When the peritoneal surfaces of the lesser omentum in the region of the cystic duct become inflamed and edematous after impaction of a stone in the cystic duct or the development of hydrops of the gallbladder, the pain may be felt in the right upper quadrant of the abdomen with direct referral or coincidental perception

of interscapular pain. This is at about the level of the sixth thoracic vertebra. In about 5% of the population the presence of fibers of the phrenic nerve in the lesser omental tissues makes it possible for inflammatory reaction in this region to be referred to the right supraclavicular region, and at times this referral during the protracted pain of an impacted stone in the cystic duct may be the most prominent feature of the pain pattern.

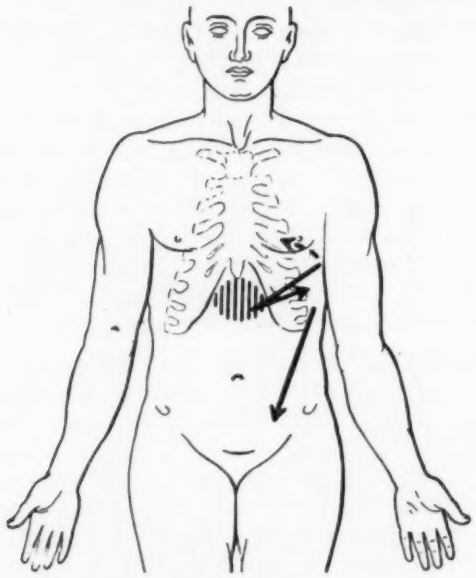

Fig. 11.—Site of pain that may occur when perforating ulcer or inflammation about a lesion in the tail of the pancreas involves perisplenic tissues.

The most deceptive type of gallbladder pain is that in which the pain is felt only to the left of the midline of the epigastrium with referral to the left side of the chest and the left subscapular region. This may occur in the absence of associated pancreatitis. It is difficult to explain but must be kept in mind as a possible explanation for some of the more obscure types of pain in the left upper part of the abdomen. This pattern probably occurs in less than 3% of cases of gallbladder disease.

Pancreatic Pain.—The pain pattern accompanying pancreatic disorders is influenced largely by the nature of the disorder (fig. 10). The pains of focal pancreatic involvement by perforating ulcer, acute diffuse pancreatitis, chronic relapsing pancreatitis, and carcinoma of the head, of the body, and of the tail of the pancreas have many features in common but some elements that confuse. As a rule, the pain of pancreatic involvement has a posterior location and is lower than expected. It usually is between the 10th thoracic and the 2nd lumbar vertebrae, commonly at the level of the first lumbar vertebra. If the lesion involves the head of the pancreas primarily, the pain may be limited to the right paraspinal region (fig. 10, left). If it involves the tail of the pancreas, the pain may be as high as the 10th thoracic segment and may be limited to the left paraspinal region (fig. 11). When the pancreas is involved diffusely or its body is involved locally, the pain is usually symmetrical in the back and may encircle the trunk. When pancreatic pain is present anteriorly it usually is in the region just above the umbilicus.

The quality of pancreatic pain is usually different from that of hollow viscera and is characterized by steadiness, prolonged duration, and great severity. The pain is usually aggravated when the patient assumes the supine position, and the patient may obtain relief by sitting with the trunk flexed and with pressure of his arms or a pillow on the epigastrium. It is characteristic for these patients to sleep sitting in a chair with the head and trunk resting on the bed. Narcotics at least as effective as morphine may be needed for the relief of such pain. If the original lesion is a perforating ulcer of the stomach or duodenum, the original visceral complaint may be so overshadowed by the pain of the pancreatic involvement that development of a new lesion rather than of a complication may be suspected. If there is a carcinoma of the tail of the pancreas with infiltration of adjacent structures, the upward shift of the pain may suggest a perforating gastric lesion. Early diagnosis in this condition is entirely dependent on a high degree of suspicion in the mind of the examining physician. If diffuse pancreatitis is present, acute pancreatic fat necrosis may be widespread and the salient features of pancreatic disease may be obscured by the presence of somatic pain as high as the mediastinal structures and as low as the perirectal structures.

Gastrojejunal Ulcer.—Secondary ulceration following gastroenterostomy or following partial gastric resection for peptic ulceration may cause visceral pain that is

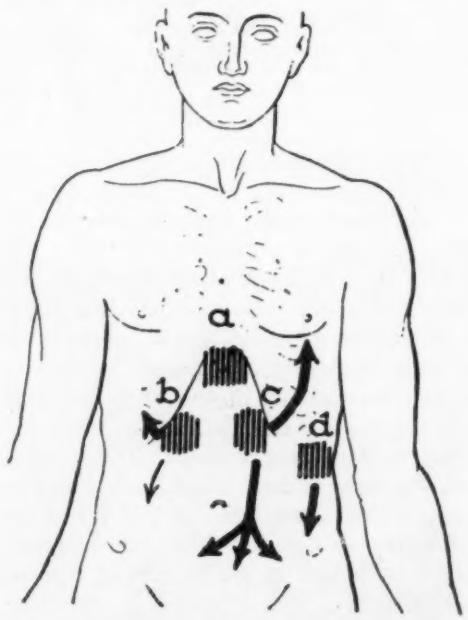

Fig. 12.—Sites of pain in anastomotic ulcer. *a*, visceral pain of uncomplicated duodenal ulcer. *b*, right shift of pain during perforation of duodenal ulcer. *c*, left and downward shift of pain of gastrojejunal ulcer involving stomach and mesocolon. *d*, downward shift of pain of perisplenic involvement.

atypical and difficult to identify because of its vagueness (fig. 12). When both the jejunum and the stomach are involved in anastomotic ulceration, somatic pain develops soon after onset of the ulceration. Because of the difference between the anatomic location of gastroenterostomy and that of anastomosis following resection, secondary pain occurs at a higher level after the latter. The involvement of the tissues about an anastomotic

ulcer will commonly give a shift of pain to the left and upward as well as a shift of pain downward to the lower part of the abdomen because of the involvement of the mesocolon. Back pain may be at a lower level and result from referral from the mesocolon or from involvement of the lower edge of the pancreas. In general, the pain is characterized by a change of the ulcer story and a shift of the pain to the left and downward. There is poor relief of symptoms of ulcer following use of the usual antacid measures, and bleeding may occur early because the jejunum is thin and is poorly resistant to ulceration.

If the gastroenterostomy, either with or without gastric resection, is anterior to the colon, the downward shift of pain may occur less commonly because the mesocolon is not involved as early. The ulcer, however, may be associated with localized tenderness over the anastomosis, and a mass may result from perforation. If the gastroenterostomy, with or without gastric resection, is posterior to the colon, the downward shift of pain may be the dominant feature of the complication. Such pain may be felt in either of the lower quadrants or in the region above the symphysis. The patient may be convinced that it has no relationship to his initial ulcer story, and his insistence may mislead the examiner. If the involvement of the mesocolon by inflammatory reaction around the perforation extends to involve the external surface of the colon, an associated irritable colon syndrome may suggest an impending gastrojejunalcolic fistula. Relief of pain in such cases may be even more effective after a bowel movement than it is following the use of antacids or food. When the development of such a fistula is consummated, all features of ulceration may disappear, being replaced by symptoms of fistula. If the gastroenterostomy followed a high resection, secondary ulceration may give such involvement of the splenic region that pain is localized in the left hypochondrium with referral to the left lower quadrant of the abdomen and to the left paraspinal region (fig. 12).

SUMMARY

Analysis of the pain produced by abdominal disorders is as good a diagnostic tool as some other procedures that are better accepted. Disorders of the upper part of the abdomen seem to have five patterns of pain. Uncomplicated lesions in the various upper abdominal organs tend to produce visceral pain with its typical location. The various complications produce pain of other types and locations. There are characteristic patterns of pain in gastric, duodenal, and gastrojejunal ulcers; cholecystic and pancreatic disease; diaphragmatic hernia; and in certain of their complications. With careful elicitation of a patient's story concerning the site and type of pain and also its time sequence, the pattern of pain can be determined and the causative lesion suggested. The relation of this information to other findings will usually establish the diagnosis.

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PROBLEMS OF OVERTREATMENT OF SURGICAL PATIENTS WITH DEPRESSANT DRUGS

Col. Harvey C. Slocum (MC), U. S. Army

The surgical patient receives every consideration necessary to relieve his pain, protect him against the psychic trauma of fear, and to insure his comfort during both the preoperative and postoperative periods. Whether the casualty be of military or civilian origin, the physician's efforts to afford adequate relief of pain may be influenced by humane instincts in that physicians tend to administer pain-relieving drugs unnecessarily. Depressant drugs such as the opiates and the barbiturates used injudiciously may be responsible for marked respiratory, circulatory, and nervous system depression that may be fatal to the seriously ill or severely injured patient.

SIDE-EFFECTS OF MORPHINE

For the alleviation of pain and suffering, morphine furnishes the primary attributes of a narcotic that are desired, namely, analgesia, euphoria, and subjective depression.[1] Many other opiates have been refined and synthesized, but most are not an improvement on morphine and have undesirable side-effects. A better understanding of the effects of overtreatment of the injured patient with opiates may be possible by considering some of the depressant and side-effects of morphine.

Respiratory Effects.—Administration of morphine causes (1) depression of the respiratory center, (2) decreased minute volume exchange, (3) decreased response of carotid body and aortic chemoreceptors to anoxia,[2] (4) decreased ciliary action in the respiratory tree,[3] (5) decreased carbon dioxide output, and (6) increased bronchial tonus. With the administration of morphine to the surgical casualty for the relief of pain, the undesirable side-effects on the respiratory system could be interpreted as decreased pulmonary ventilation and inadequate gaseous exchange, with resulting hypoxia and carbon dioxide excess; and depression of the ciliary "janitor service" that, with the cough reflex, is responsible for keeping the lung fields clean.

Circulatory Effects.—The circulatory effects of morphine are mostly secondary to respiratory depression. They include (1) decreased venous return to the heart

From Walter Reed Army Hospital, Washington, D. C.

Read in the Symposium on Pain: Causative Mechanisms, Effects, and Therapy, before the Section on Joint Meeting of the Section on Anesthesiology, the Section on General Practice, and the Section on Military Medicine at the 103rd Annual Meeting of the American Medical Association, San Francisco, June 25, 1954.

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with large doses, (2) decreased cardiac output with large doses, (3) decreased peripheral vascular circulation,[4] (4) depression of the vasoconstrictor center, (5) hypotension, (6) circulatory depression with postural change, (7) masking signs of asphyxia,[5] and (8) dilution of blood volume. In the surgical patient the undesirable side-effects of morphine on the circulatory system could be interpreted as depression of circulatory function with hypotension, and decreased compensation to trauma, shock, hemorrhage, hypoxia, and postural change.

Nervous System Effects.—The effects of morphine on the nervous system are (1) delirium, (2) nausea and emesia, (3) increased intracranial pressure, (4) decreased autonomic reflexes, (5) depression of heat-regulating center, and (6) allergic (histamine) response. In the surgical patient the undesirable side-effects of morphine on the nervous system could be interpreted as, first, decreased self-control of the patient with lack of cooperation, in which instance an ambulatory patient would become a bed patient. Second, emesia leads to loss of fluid and electrolyte, which aggravates the pre-shock or shock condition. Danger of lung field contamination always exists. Third, increase of intracranial pressure may precipitate a respiratory crisis or circulatory collapse. Fourth, midbrain depression, with decreased control of vital reflex centers, diminishes the protective and compensatory controls of all systems.

Metabolic Effects.—The metabolic effects of morphine are (1) decreased cell permeability and tissue uptake of oxygen, (2) decreased liver function, (3) decreased kidney function, (4) increased electrolyte output,[6] and (5) decreased endocrine function, pituitary-adrenal axis. In the surgical patient the undesirable side-effects of morphine on the metabolic system could be interpreted as decreased hepatic blood flow, with impaired detoxification of drugs and tissue toxins, depression of the enzyme and hemopoietic systems, reduction of metabolic function at least 10%, decrease in urinary output and resorption of electrolyte, decreased carbon dioxide combining power with upset of the acid-base balance, retention of nitrogenous wastes and urinary retention, depresssion of the pituitary-adrenal response to stress, and decreased epinephrine output and loss of vasomotor tonus.

Gastrointestinal Tract.—Morphine effects on the gastrointestinal tract are (1) decreased propulsive and non-propulsive contractions of the upper small intestine with intermittent spasm,[7] (2) decreased motility of stomach and colon,[8a] (3) increased tone and amplitude of contractions of the pylorus and sphincter of Oddi,[8a] and (4) primary inhibition of gastric secretions. In the surgical patient the undesirable side-effects of morphine on the gastrointestinal tract could be interpreted as increased emptying time with increased irritability to stimulus from the vomiting center and decreased motility and spasm of the intestine, with retention of toxic waste products.

CRITERIA FOR MORPHINE THERAPY

In most healthy patients the depressing effects of morphine produce only minimum clinical response to the physiological variables of the drug in small doses. However, in the debilitated patient, one with traumatic or hemorrhagic shock, disrupted respiratory mechanism, depressed central nervous system, or hypofunctional metabolism, the effects of morphine may be acute.[8b] Because of the action and side-effects of this drug it should be withheld from surgical patients classified as: (1) the ambulatory patient, (2) the patient with head injury (except for severe pain), (3) the hysterical patient, (4) the patient with chest injury (except for severe pain), and (5) the patient in shock.

The surgical patient is evaluated as to type of injury, degree of nervous system depression, and respiratory and circulatory status. Resuscitative measures are instituted, such as establishment of a patent airway, oxygen, blood, plasma or substitutes, closure of sucking wounds of the chest, tourniquet, pressure bandages to areas of hemorrhage, and morphine to only those in severe pain.[8b] An attempt should be made to differentiate true pain from hysteria and discomfort that can be relieved by small doses of barbiturates given intravenously.[8b] It would seem that the most severely injured patients require the least amount of pain relief. This is probably due to the numbing effect of shock.[8b] Penetrating wounds of the abdomen; compound fractures of the long bones; traumatic amputations, particularly in the upper thigh; and trauma to the nerve roots of the spine may be extremely painful until morphine or the effects of shock diminish pain perception. Extensive superficial burns may be painful when deep burns have destroyed the sensory nerve endings. In some instances pain may cause neurogenic shock that can be relieved in part by the administration of morphine.

DOSAGE

The injudicious use of morphine may precipitate the patient into a state of physiological deterioration by interfering with the normal compensatory mechanisms that

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are barely holding their own against inadequate oxygenation, decreased cardiac output, inadequate circulating volume of blood, dilatation of the peripheral vascular bed, and decreased autonomic tone. When administered subcutaneously to the patient in circulatory depression morphine becomes effective only after reestablishment of peripheral vascular circulation. In such cases administration of the drug may be repeated because of the lack of effectiveness of the previous dose. With return of adequate circulation the patient absorbs an overdose, with resulting signs of morphine poisoning.[8c] Recently, nalorphine hydrochloride has been used successfully to combat the acute depressant effects of morphine, meperidine (Demerol) hydrochloride, codeine, and other opiates.

The amount of morphine indicated for the relief of pain has been studied by many workers.[8] Beecher has shown that many patients receive adequate relief of pain from a single dose of morphine, and that only 25% of surgical casualties entering the hospital need further pain relief.[8h] It is generally conceded that 10 to 15 mg. of morphine is adequate in most cases.[8l] Intravenous administration will produce more satisfactory results more rapidly and allow for observation of side-effects within a few minutes.[8k] Attempts have been made to potentiate the effect of morphine, thus decreasing the amount necessary for pain relief by combining it with other drugs such as neostigmine (Prostigmin), barbiturates, and procaine.

CONCLUSIONS

In the immediate postoperative period the condition of the surgical patient may show a status of depressed vital functions similar to that of the patient before operation plus the added effects of surgery and anesthesia. Even though adequate support to respiration and circulation has been established, it is recognized that further physiological insult may have disastrous results. The routine use of morphine on a time schedule, whether the pain requires it or not, is not an uncommon practice. Frequently, it is used for relief of general mental and physical discomfort when good nursing care and small doses of a barbiturate would suffice. On occasion, morphine has been used when the patient's restlessness was due to hypoxia and oxygen therapy was the indicated choice of therapy. As a result, the postoperative morbidity is increased by instances of shock, depression, atelectasis, loss of vasomotor compensatory control, and long bouts of nausea and emesia with loss of fluids and electrolytes. The increase in morbidity not only leads to an extension of necessary hospital care but frequently increases the mortality rate. In either the preoperative or the postoperative period, the overtreatment of the surgical patient tends to depress the vital functions that control the compensatory mechanisms of homeostasis. Waters,[6j] in his well-known article, "The Cost of Comfort," has warned that it is the patient who must pay the price.

ROLE OF PHYSICAL MEDICINE IN RELIEF OF CERTAIN PAIN MECHANISMS OF SHOULDER

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Treatment by physical means is probably the oldest form of therapy for the relief of pain. The test of time, the accumulated knowledge of continuing research, and a long background of clinical experience now find physical medicine an integral part of medical practice. In addition, there are physicians who specialize in the practice of physical medicine. There is at present a sharp shift of emphasis away from the use of the physical agents per se toward functional restoration as the primary therapeutic factor. Musculoskeletal pain is usually intimately related to disturbances in the dynamic functions of muscles and joints. In considering methods of relieving pain, therefore, the specific nature of the alteration of function associated with the pain must be understood. Physical medicine thus has diagnostic and therapeutic functions, in the clinical sense. It is used not merely for the treatment of pain, but rather for the treatment of pain caused by and as a direct result of something specific. It is necessary, therefore, to obtain a detailed history of the origin and course of the pain and to conduct an examination to demonstrate the specific factors responsible for the pain. The examination goes beyond the discovery of the pathological diagnosis to the recognition of the functional diagnosis. This pertains to the specific abnormalities that are interfering with normal body mechanics. Physical medicine is not used for the treatment of injury or disease such as fractures, dislocations, arthritis, or diabetes but is directed toward the limitation of range of motion of joints, spasm, loss of elasticity, weakness, shortening, imbalance, and other abnormalities of muscle function. It is only after careful evaluation of the history, correlation of this history with the symptoms complained of, and a detailed intelligent examination and discovery of the functional elements involved that specific treatment, by way of physical medicine, can be determined.

From the therapeutic standpoint, physical therapy is given for the relief of pain, so that the functional approach to the specific dynamic defect can be tolerated. In the long run, in terms of relief of pain without recurrence, restoration of normal function is essential. The use of various forms of heat is excellent preparation for specific treatment that may consist of stretching tight or fibrotic muscles; regaining part of lost motion at a tight joint; exercising weak muscles against appropriate resistance; or giving coordination exercises, occupational therapy, or ambulation training. It is extremely important to grasp the implication of the sequence of treatment in order to be in a position to expect satisfactory results from phys-

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ical medicine. When a fracture heals or arthritis has run its course the residual pain and physical disability do not disappear spontaneously. It is these residuals and not the fracture or inflammatory process that still require treatment. The empirical use of diathermy and other forms of heat for the treatment of pain alone is not good medicine. It is no better than giving penicillin to every patient who has a fever without examining him.

CAUSE OF PAIN IN THE SHOULDER

Two groups of conditions producing pain in the region of the shoulder account for about 75% of all painful shoulder problems, and, at the same time, they are generally not well understood. Group 1 is composed of pain caused by gravitational or postural stress. Group 2 comprises a large number of conditions that are sequelae or adaptive changes in the shoulder and shoulder girdle secondary to specific disease—the "chronic" shoulder. Painful shoulder caused by postural or gravitational stress is encountered frequently by every physician. This is not an injury or disease; rather it is mechanical, functional, and reflex in nature. The commonest type of such pain is the scapulocostal syndrome, a clinical entity in which the symptoms manifest themselves in one or more of four regions of distribution: 1. The pain may originate at the root of the neck and radiate outward across the shoulder and down the arm to the fourth and fifth fingers. 2. The shoulder may not be involved. There may be a girdle-like pain beginning at the scapula, radiating around the chest to the sternum. This is often mistaken for angina when it occurs on the left side. 3. There may be radiation of pain to the neck and occiput associated with occipital headache. 4. There may be pain at the shoulder alone without radiation.

The scapulocostal syndrome occurs in primary form in middle-aged persons who have poor posture or who work in a stooped position. The symptoms are due to the changed relationship of the scapula to the underlying thoracic cage. Two mechanisms are present: an area of sensitivity in the soft tissues under the scapula and a chronic state of fatigue of the shoulder girdle muscles. A trigger point is usually present at the vertebral border of the scapula near the superior, medial angle. The trigger point is found by pressing the examining thumb along the vertebral border of the scapula when it is drawn laterally. This trigger area develops after continuous tension on the subscapular tissues. The muscular fatigue symptoms result from constant tension on the muscles suspending the scapula without providing an opportunity for them to relax or shorten. The radiation patterns are reflex in nature and do not involve irritation of peripheral nerves. When scapulocostal symptoms are chronic, there is persistent trapezius muscle spasm, and many of the muscles may become hard, sensitive to touch and stretch, and inelastic. This is often referred to as myositis, fibrositis, or faciitis, but these secondary changes are not the cause of the pain; they are the adaptive tissue changes characteristic of chronicity. Considerable muscular weakness from disuse and secondary changes may be present. The condition is usually mistaken for cervical arthritis, protruded intervertebral disk in the neck, scalenus anticus syndrome, or many other conditions implicating the peripheral nerves. The scapulocostal syndrome is very common and occurs as frequently as all other causes of shoulder girdle pain combined. It is postural, mechanical, and reflex and must be recognized for what it is. Heat, massage, and drugs have only a transient effect on it.

TREATMENT

The principles of treatment involve the relief of pain, correction or alleviation of the postural stress factor, and reestablishment of normal muscular strength and balance of the shoulder girdle. Infiltration of procaine (Novocaine) hydrochloride at the trigger point is probably the best means of relieving the local and reflex pain. Ethyl chloride spray often is very effective for relaxing the widespread muscle spasm. Stretching tight muscles, manually or by means of head halter traction, is frequently necessary. General postural exercises and strengthening exercises for weak muscles may then be given. The key to the situation, however, is the relief of persistent postural pull on the muscles. This is accomplished by changing the type of seat for a bench worker, prescribing a support for the patient with a protuberant abdomen, or a low back support for a woman with exaggerated curves of the lumbar or dorsal spine. Attention to individual requirements is the basis for success. All patients should be made conscious of their posture in walking, working, and sleeping. At work, most persons require a change in position, at one or two hour intervals, to get out of the bent-over attitude, and stretch, and relax. This may take only two minutes but is basic in controlling recurring attacks. Other postural syndromes involving muscle spasm and syndromes in which trigger points and reflex pain develop are present about the neck and shoulder. The principles of treatment are the same. In diagnosing the scapulocostal syndrome, glenohumeral motion will be observed in normal range. Scapulohumeral rhythm is impaired owing to muscle spasm.

In contrast is the second group of conditions, in which pain in the shoulder is associated with loss of motion in the glenohumeral joint. This may follow acute bursitis, fractures about the shoulder, rheumatoid arthritis, prolonged bed rest, or disuse from a variety of causes. When the primary pathological condition subsides and the shoulder becomes stiff or frozen the mechanism is mechanical. It is due largely to adherence of moving structures to each other. It is then too late for cortisone or other drugs to be of more than transient value, and physical medicine alone is effective for relief of pain and correction of the functional impairment. Examination must be made to identify the extent of muscle spasm, loss of abduction and rotary motions at the glenohumeral joint, and secondary changes in the muscles.

Release of spasm may be accomplished by infiltration of trigger areas, if they can be located; frequently they cannot. Spraying the muscles with ethyl chloride appears to be a very efficient procedure, since there is such widespread involvement of muscles that no single or multiple method of injection can reach all of the muscles. The use of superficial heat, in the form of low intensity diathermy, hot packs, or infrared rays is quite effective when followed by gentle, stroking massage from a person who is capable of recognizing what is taking

place under the hands, until the patient is completely relaxed. After this, passive movements are carried out to the point of tolerance and a little further, even in the presence of increased pain. Active movements, however, should not be carried out beyond the point of pain since there is no benefit to the patient. It is permissible to produce pain on passive movements, because these movements are designed to place tension or stress on the limited articular or periarticular structures about a joint or to stretch muscles that are inelastic, tight, or short. Active movement, however, can be beneficial only when the patient makes a maximal effort. This is not possible in the presence of pain. Passive movement for very tight or frozen shoulders must be accomplished along special lines. Simply pulling the arm out or using a pulley does further damage by jamming the tissues between the tuberosities of the humerus and the acromion. In attempting to restore movement in a very tight shoulder it is necessary to (1) use heat, massage, and relaxation, (2) apply constant traction for a moment or two, and (3) restore rotary movements, particularly external rotation, before any attempt is made to abduct the arm. In the movement of abduction, it is necessary that exernal rotation be present, since, in abducting the arm away from the body, involuntary external rotation of the head of the humerus takes place, and, if this is restricted by the periarticular tissues, it does no good to passively abduct the arm. In the adaptive changes due to disuse or post-inflammatory conditions the muscles about the shoulder become indurated, sensitive to touch, and particularly sensitive to stretch. The use of physical medicine here is extremely important. X-ray therapy is used with very questionable success. The use of heat and the appropriate type of massage will usually alleviate the pain sufficiently so that the patient can tolerate the passive and active exercises. If trigger points are found, these should always be injected prior to treatment. Tender areas are not helped by infiltration of procaine hydrochloride.

From a preventive standpoint, considerable diminution can be accomplished in the difficulties anticipated after specific pathological conditions about the shoulder. In fractures, dislocations, bursitis, and other acute shoulder conditions, when the primary pathological process is under control, Codman's and other pendulum exercises should be used to draw the arm away from the trunk without voluntary effort. This does not prevent the formation of adhesions in the periarticular structures; they occur anyway, but they do not occur between fixed points. The tissue reaction, however, in the presence of an increased blood supply by the application of heat and massage and a combination of preventive exercises, ultimately results in less disability.

SUMMARY

Physical medicine, in its diagnosis and therapeutic aspects, plays an important role in the treatment of two groups of conditions causing pain in the shoulder girdle. The palliative pain-relieving effects of the physical agents are preparatory to functional restoration as a basis for prolonged relief or cure. Certain painful shoulder girdle conditions can be completely managed by physical medicine alone, since carefully prescribed treatment on specific indications is highly effective when insight is developed into the causal relationship between pain and functional abnormalities.

400 E. 34th St. (16).

EVALUATION FORM FOR TISSUE COMMITTEES

SUGGESTED METHOD FOR TABULATING DECISION AS TO JUSTIFICATION FOR SURGERY

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The tissue committee of a hospital medical staff evaluates the justification for surgery performed by the staff of that hospital. This is the first step toward the critical evaluation of the quality of surgical care given hospital patients and is now required by the Joint Commission on Accreditation of Hospitals. However, few hospitals have tissue committees that are providing an effective evaluation of surgery at the present time, and there are several reasons for this. 1. The clinical justification for surgery is frequently disregarded. It must be recognized that a certain percentage of normal tissue will be removed for adequate clinical reasons by any surgeon. Whether the operation is justified in each case is a decision to be made by the clinicians of the tissue committee. 2. The preoperative diagnoses frequently are not obtained from the operating surgeon and recorded on the chart before surgery. 3. Not all surgical tissues are diagnosed honestly. Some surgeons are reluctant to accept "normal tissue" as an accurate diagnosis. Some pathologists are coerced into attempting to report some pathological process in every specimen. 4. Some physicians are unwilling to criticize the surgery of a colleague. 5. The decisions of the tissue committee are sometimes not recorded properly, making it difficult or impossible to evaluate the surgery later. 6. The scope of the tissue committee's work is not realistically adjusted to the amount of time that busy physicians can devote to such evaluation.

Experience has shown that unjustified surgery occurs most frequently in certain types of surgical procedures, mainly appendectomies and gynecologic surgery. Accurate diagnosis of all tissue removed in these operations and a careful evaluation of it, plus objective evalua-

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tion of all surgery in which normal tissue is removed, no tissue is removed, and significant differences exist between preoperative and tissue diagnoses, will practically insure proper evaluation of the surgical work. To attempt more may impose an impossible burden on the tissue committee. In order to assess the results of each surgeon's work effectively, it is advisable for the tissue committee to evaluate, at one time, similar operations done by all staff surgeons. Thus, all primary appendectomies are evaluated in one group, all hysterectomies in a second group, all cholecystectomies in a third group, etc. By this means the diagnostic accuracy, the amount of normal tissue removed, and, most important, the justification of surgery for a specific operation can be determined for individual surgeons or for all surgeons. Appendixes removed incidentally to some other procedure, such as hysterectomy, are examined by the pathologist but are not included in such a tissue review. They must be of concern to the tissue committee when the operative risk may have been increased by the appendectomy.

			I. DISEASE				II. NO DISEASE				III. NO TISSUE REMOVED			
			A. Surgery Justified		B. Surgery Not Justified		A. Surgery Justified		B. Surgery Not Justified		A. Surgery Justified		B. Surgery Not Justified	
											Preoperative and Final Diagnoses			
Preoperative and Tissue Diagnoses Agree →			1. Yes	2. No	1. Yes	2. No	1. Yes	2. No	1. Yes	2. No	1. Yes	2. No	1. Yes	2. No
Hospital Case	Surgeon	Final Diagnoses, Operation												
1054	33	Acute appendicitis	X											
1086	4	Chronic appendicitis			X									
1092	16	Ruptured ovarian follicle						X						

Sample form to be used by hospital tissue committee in evaluating surgery.

EVALUATION FORM

To tabulate the opinions of the tissue committee efficiently and effectively and to make its labors easier, the form given in the figure is suggested. Its success depends on forthright pathologists and sincere, judicious, and cooperative clinicians. The types of surgical cases to be reviewed by the tissue committee are decided by that committee. The medical records librarian, with advice from the pathologist, can then separate the records into the following categories: I, that in which the surgical tissues show disease on examination by the pathologist; II, that in which the surgical tissues show no disease on such examination; and III, that in which no tissue is removed (such as exploratory laparotomy, lysis of adhesions, tubal ligation). Members of the tissue committee then have the responsibility of justifying the surgical procedures in the three categories. Each patient's record, history, physical examination, laboratory data, diagnostic tests, operative findings, follow-up notes, and discharge note provide the basis for determining such justification. The accuracy of preoperative diagnosis is also determined by the tissue committee members.

Use of the form is simple. The hospital number of each case is placed in the designated column, and the surgeon's code number is given in the adjacent column. The final diagnosis (or name of operation if all surgery of one or more surgeons is being evaluated) is placed in the appropriate section. Opposite these statistical data, a check is placed in the column that corresponds to the evaluation of the tissue committee in that case; for example, the patient of case 1054 had an appendectomy, with a preoperative diagnosis of acute appendicitis. This was substantiated by the tissue diagnosis, leading to an evaluation that the operation was justified and a classification of I A 1 (see figure). The evaluation of the surgery of the patient in case 1086, who had an appendectomy with a clinical diagnosis of "chronic appendicitis," in which the pathologist's diagnosis was "chronic appendicitis," would be I B 1, if the operation was not justified in the opinion of the committee. On the other hand, the surgery of the patient in case 1092, who had an appendectomy with the preoperative diagnosis of "acute appendicitis" would be evaluated as II A 2 (no disease of the appendix, surgery justified, and preoperative and tissue diagnosis disagree) if a ruptured ovarian follicle or some other condition was found that caused signs and symptoms of an acute abdominal condition requiring surgery.

Operations in which tissue is not removed, such as lysis of adhesions, uterine suspension, and tubal ligation, may be evaluated by recording the opinion of the tissue committee in category III. In this instance, the preoperative and final diagnosis are compared, since no report on the tissue is possible. When two operative procedures are done at the same time, tissue from each is considered; for example, removal of a normal appendix may be justified, II A 2, in the instance of a ruptured ovarian follicle, indistinguishable clinically from "acute appendicitis." If the ovary is needlessly removed in such a case, however, a separate entry for the removed ovary is made and the surgery is classified as II B 2 (no disease of the ovary, operation not justified, and incorrect preoperative diagnosis). Decisions of greater difficulty, such as failure to remove a chronically inflamed cervix during an indicated and justified hysterectomy for leiomyoma, may be resolved similarly by a double entry, I A 1 for the hysterectomy, and III B 1 for the unremoved cervix; however, the second entry may be avoided by the use of a separate sheet if this better serves the purpose of review.

This form can serve as a tabulation of: (1) a specific operation by all surgeons, (2) a specific operation by an individual surgeon, (3) all operations by all surgeons, or (4) all operations by an individual surgeon. The total of I A, II A, and III A will furnish the number of justified surgical procedures. The total of I A and II A will give the number of operations in which tissue was removed justifiably. The total of II A and II B will

provide the number of operations in which normal tissue was removed. The total of I A 1, I B 1, II A 1, II B 1, III A 1, and III B 1 will furnish the number of operations in which the correct preoperative diagnoses were made. From the above data certain rates in percentages can be determined.

$$\text{Justified operation rate: } \frac{\text{I A} + \text{II A} + \text{III A}}{\text{I} + \text{II} + \text{III}}$$

$$\text{Justified tissue removal rate: } \frac{\text{I A} + \text{II A}}{\text{I} + \text{II}}$$

$$\text{Normal tissue removal rate: } \frac{\text{II A} + \text{II B}}{\text{I} + \text{II}}$$

$$\text{Accuracy rate of preoperative diagnosis: } \frac{\text{I A 1} + \text{I B 1} + \text{II A 1} + \text{II B 1} + \text{III A 1} + \text{III B 1}}{\text{I} + \text{II} + \text{III}}$$

AUDITS OF SURGICAL PERFORMANCE

This method of evaluating surgical performance has been used by one of us (R. S. M.) for the past two years in audits of surgery of numerous hospitals. It has also been used by several hospital tissue committees to test its effectiveness. The table gives statistics for consecutive appendectomies and hysterectomies obtained by use of this method in several hospitals of various sizes and locations and with and without intern and residency training programs. From the table it is apparent that hospitals 3, 6, 7, and 8 have excellent rates for justified surgery in appendectomy and that each of these hospitals has a competent and effective tissue committee, has rigid standards for surgery, and discourages appendectomy for so-called chronic appendicitis. Excellent rates for justified surgery in hysterectomy are indicated for hospitals 1, 3, 7, and 8. Hospital 1, which had only a mediocre justified surgical rate for appendectomy, 86%, had a rigidly enforced staff regulation requiring consultation before gynecologic surgery, which accounts for its excellent justified surgery rate in hysterectomy. It is evident that the time-honored standard for judging surgery, a normal tissue rate of 10 to 15% for all surgery, is not adequate. The percentage of normal tissue removed seems to vary widely with the organ removed, and there is not a sufficiently close correlation with the justified surgical rate to provide a valid index of surgical performance. At hospital 4, with a justified appendectomy rate of only 76%, there was no normal tissue removed because the pathologist at that hospital claimed that no appendix was "normal" and used the diagnosis of "chronic" or "subacute" for all appendixes not acutely inflamed. Hospital 3, with an excellent justified appendectomy rate, 94%, had a normal tissue removal rate of only 4%, but this was an institutional hospital of a university with only male students. Diseases peculiar to women that may mimic acute appendicitis were not a factor here. On the other hand, hospital 8, with an outstanding justified appendectomy rate, 97%, had a 14% normal tissue removal rate. Hospital 5, with an entirely forthright pathologist, no tissue committee, and no discernible standards for surgical performance, had a poorly justified surgical rate, 59%, and 38% of the tissue was normal.

In hysterectomy, there appears to be no valid correlation at the present time between the percentage of justified surgery and the percentage of normal tissue removed. Hospital 4, with a poor rate of justified hysterectomy, 68%, had no normal tissue removed because the pathologist never returned a diagnosis of normal tissue. Hospital 7, with 100% of justified hysterectomies, had 45% of normal tissue removal after justified vaginal hysterectomy done for uterine prolapse, while hospital 3 had a 94% justified hysterectomy rate with a 22% normal tissue removal rate for the same reason. Emphasis should be placed by the tissue committee on the clinical justification for surgery, and the decisions should be honestly and fearlessly recorded. Hospitals using a method such as the one herein suggested can provide the answer to acceptable rates for justified surgery and for normal tissue removal for specific operations.

Surgical Performance Statistics

				Appendectomy					Hysterectomy				
Hospital No.	No. of Beds	Location	Interns, Residents	Total Operations	Justified, %	Not Justified, %	Accuracy of Diagnosis, %	Normal Tissue Removal, %	Total Operations	Justified, %	Not Justified, %	Accuracy of Diagnosis, %	Normal Tissue Removed, %
1	250+	Urban	Yes	49	86	14	70	27	29	100	0	93	10
2	500+	Urban	Yes	31	77	23	77	0	50	82	18	74	12
3	300+	Rural	Yes	49	94	6	86	4	36	94	6	97	22
4	50+	Rural	No	198	76	24	63	0	119	68	32	71	0
5	50+	Rural	No	37	59	41	56	28	32	78	22	100	69
6	250+	Urban	Yes	100	97	3	84	9	Not Assessed				
7	125+	Urban	Yes	91	97	3	88	12	81	100	0	100	45
8	200+	Urban	Yes	77	97	3	83	14	34	97	3	97	3

40 E. Erie St. (11) (Dr. Myers).

Cleft Lip and Palate.—Cleft lip and palate occur with regularity in one birth in a thousand. The only recognized etiological factor is heredity, though since one or two generations may be unaffected its application is often obscure. . . . In 50% of cases the cleft extends right through lip and palate, while in the remaining 50% clefts confined to the lip or palate are of approximately equal occurrence. There is an unequal distribution between the sexes, boys being the subject of cleft lip twice as often as girls, while the ratio is reversed in the palate. The left side of the lip is more often affected than the right, and single clefts of the lip are three times as common as the double clefts.—W. G. Holdsworth, M.D., Cleft Lip and Palate, *Medical Press*, Sept. 22, 1954.

CLINICAL NOTES

ELECTROENCEPHALOGRAPHIC RECORDING OF A DEATH DUE TO NONTOXIC CAUSES

Leslie J. Seeley, M.D., American Lake, Wash.

This is the report of an electroencephalographic recording made at death in a patient with no brain disorder, no reliable history of head injury, and no history of noxious poisoning by such agents as barbiturates or carbon monoxide. The patient was a 39-year-old, white male, whose personality pattern was that of an antisocial psychopathic inferior, with periodic psychotic manifestations. A routine electroencephalographic recording, customary at this hospital, was made. After a waking record, the patient was given 10 grains (0.65 gm.) of chloral

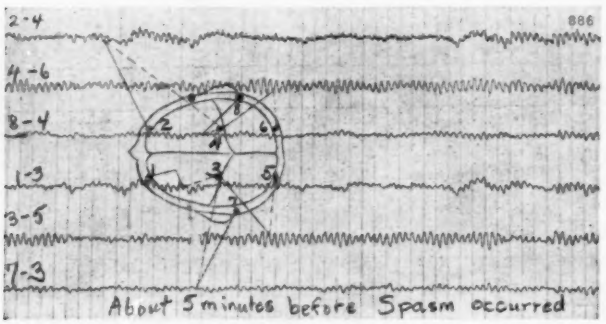

Fig. 1.—Recording made five minutes before spasm, with normal alpha rhythm of 9 to 9½ cps and an average amplitude of 45 μv, sinusoidal in character.

hydrate to induce sleep. Records made both while he was awake and asleep were completely normal. He was then instructed to hyperventilate, which he did adequately. The routine record was finished. The recording was then stopped, and the technician began to remove the electrodes. Suddenly, the patient had a spasm, turning his head to the left and struggling for air. The record was restarted, without the right temporal lead, which was replaced later.

It is obvious that the patient's record was completely normal prior to the cardiac spasm (Fig. 1). The alpha rhythm was well organized, sinusoidal at 9½ to 10 cps. About five minutes after the spasm the record revealed a slowing of brain waves to 6 cps (Fig. 2*A*). There were muscle spasms when the patient struggled for breath. Two minutes and 10 seconds after *A* the waves had slowed to infrequent bursts of 4 to 4½ cps and were much lower in amplitude (Fig. 2*B*). Three minutes after *B* the record became almost flat, except for two feeble bursts of about 4 cps. Then all brain waves stopped (Fig. 2*C*). The flattened record was synchronous with the cessation of heart sounds. Talbot [1] has recorded some studies in subjects dying from barbiturate poisoning. This man's death was caused by coronary thrombosis and occlusion of the right coronary artery.

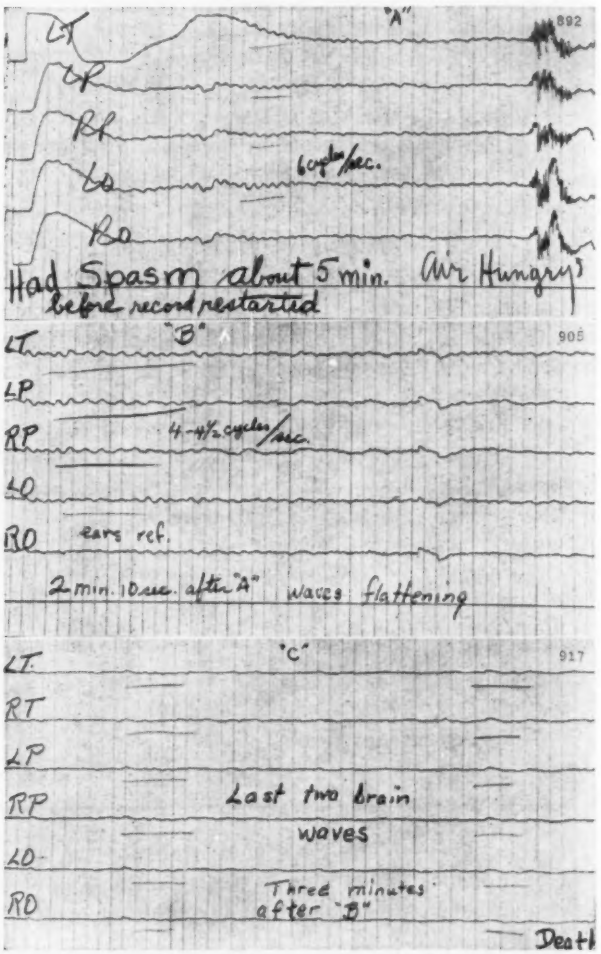

Fig. 2.—Gradual cessation of brain waves after a prompt slowing following coronary occlusion spasm. *A*, recording made five minutes after spasm. *B*, recording made two minutes and 10 seconds after *A*. *C*, recording of last two brain waves.

CONCLUSIONS

Anoxia and the sudden depletion of other vital factors produced a prompt swing from a normal brain wave pattern to a paroxysmal slowing pattern. This differs from barbiturate poisoning, as demonstrated by Talbot,[2] in that the latter record is rapid (14 to 16 cps) in coma, gradually slowing to paroxysmal bursts and then the cessation of brain waves with death.

From the Veterans Administration Hospital.

1. Talbot, D. R.: Use of EEG to Prevent Electroshock Fatalities in Barbiturate Induced Psychoses, Proceedings of the Western Society of Electroencephalography, Electroencephalog. & Clin. Neurophysiol. **6**: 347 (May) 1954.

2. Talbot, D. R.: Electroencephalographic Evidence of Barbiturate Poisoning Damage to the Central Nervous System, Proceedings of the Western Society of Electroencephalography, Electroencephalog. & Clin. Neurophysiol. **1**: 112 (Feb.) 1952.

Emergency Cases.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.—Principles of Medical Ethics of the American Medical Association, chapter 6, section 5, June, 1954.

COUNCIL ON PHARMACY AND CHEMISTRY

REPORT TO THE COUNCIL

The Council has authorized publication of the following report from the Committee on Research.

R. T. STORMONT, M.D., *Secretary.*

For the guidance of the practicing physician, the Subcommittee on Steroids and Hormones of the Council's Committee on Research has prepared the following general outline of management for advanced, inoperable mammary carcinoma directed toward alteration of steroid metabolism.

PAUL L. WERMER, M.D., *Secretary, Committee on Research.*

THERAPEUTIC ALTERATIONS OF STEROID METABOLISM IN ADVANCED MAMMARY CARCINOMA

PRELIMINARY ROENTGENOTHERAPY

Inoperable breast carcinoma, whether primary or metastatic, original or recurring postoperatively, should have palliative roentgenotherapy preliminary to treatment by alteration of steroid metabolism, if the dominant lesions may be irradiated effectively. The one exception to this rule is that of distant metastatic lesions of soft tissue (not local recurrence) in women five years or more postmenopausal; for these patients preliminary palliative treatment by estrogens seems preferable. (The postmenopausal phase is defined as the period of time beginning with the last known menstrual period.) All major areas of skeletal involvement with significant weight-bearing function should have the benefit of roentgenotherapy, regardless of other management.

CHOICE OF TREATMENT

Artificially Induced Menopause.—Artificially induced menopause should precede the use of androgenic hormone in premenopausal patients with inoperable mammary carcinoma. In the absence of medical contraindications, bilateral oophorectomy seems the preferable method. Menopause induced by roentgenotherapy is a satisfactory procedure for women 40 to 60 years of age, provided that a dosage of 600 to 1,200 r is delivered to the midpelvis in a minimum period of 10 days. In younger women, larger dosage is necessary. About one-third of the patients will have early objective regression of disease after artificially induced menopause. Hormones should not be used in these responsive patients until clinical evidence of active disease is again apparent.

Hormones.—The hormone of choice is related to the patient's physiological age in reference to the menopause. Up to, and for a period of five years after the menopause, whether natural or by artificial induction, the initial steroid of choice is androgenic hormone; after this arbitrary period, estrogenic hormone is more generally useful.

INITIAL TRIAL OF TREATMENT

Objective changes in breast cancer occur slowly with altered steroid metabolism and may not be apparent for three months or longer. Therefore, any attempt to alter steroid metabolism should be pursued for a minimum period of three months (if contraindications do not develop) before significant evaluation of effectiveness is possible. During this time, observation at intervals of one to three weeks is essential, with careful inquiry as to symptomatic response and development of side-effects. If the disease remains static, treatment should be continued. If objective evidence of unaltered progression of the disease is apparent during the trial period, the method of treatment should be changed. Increase in pain during the first two weeks of treatment is not uncommon and is not an indication for change of treatment. Later in the course, pain may be a significant indication of progression.

PLANS OF TREATMENT WITH STEROID AGENTS

The standards of reference for treatment are: androgen-testosterone propionate in oil, 50 mg. three times weekly by intramuscular injection; estrogen-diethylstilbestrol orally, 15 mg. daily, usually in three divided doses. If objective response is achieved, these dosage schedules should be maintained until reactivation of disease is apparent. The Committee has no data indicating any superiority in tumor-suppressing effect by any androgen or estrogen over that obtainable with testosterone propionate and diethylstilbestrol; however, other androgens and estrogens have demonstrated definite tumor-suppressing effect comparable with testosterone and diethylstilbestrol.* The following dosages have been employed:

A. Estrogens
   1. Oral
      a. Ethinyl estradiol, 3 mg. daily
      b. Conjugated estrogenic substances, 30 mg. daily
      c. Dienestrol, 15 mg. daily
      d. Dimethyl ether of diethylstilbestrol, 30 mg. daily
   2. Parenteral (For the patient who cannot tolerate oral medication, injectable estrogens may be substituted.)
      a. Estradiol benzoate, 5 mg. three times a week
      b. Estradiol dipropionate, 5 mg. twice a week

B. Androgens
   1. Oral
      Methyltestosterone, 100 mg. daily, preferably 25 mg., four times a day
   2. Parenteral, short duration
      Stanolone,† 100 mg. three times a week
   3. Parenteral, long duration
      a. Testosterone cyclopentylpropionate, 200 mg. every two weeks
      b. Testosterone phenylacetate, 200 mg. every two weeks

Caution: Long-acting androgenic preparations are effective tumor-suppressing agents; however, their use involves certain inherent risks in the event of complications, because their action cannot be interrupted quickly. The Committee believes that prior to the use of long-acting preparations there should be an adequate trial test of responsiveness to androgenic therapy by use of testosterone propionate or other short-acting androgen.

SECONDARY PLANS OF THERAPY

For the patients not responding to initial therapy, or those escaping control after initial regression, the following sequence of further management is advised. 1. Failure of control or reactivation of disease after artificial induction of menopause is an indication for institution of androgenic therapy. 2. Failure of control or reactivation of disease after hormone administration should be followed by withdrawal of hormone therapy for one month, as some patients will then show regression and should have no further treatment until reactivation of disease is evident. 3. Patients not responsive to androgens, and who have not had bilateral oophorectomy, should have this performed. If oophorectomy has been done, experience has shown that a cautious trial of estrogens may be effective. 4. Postmenopausal patients with disease not controlled by estrogens may have a trial of androgens, given in the dosages described.

HAZARDS

Emphasis should be placed on the most dangerous side-effects of steroids: fluid retention, in early phase of treatment, and hypercalcemia. Both are commoner in patients with cardiovascular-renal disease, which may be latent in elderly patients and may become apparent only after initiation of steroid therapy. Such concomitant disease makes these complications more ominous, requiring more frequent observations in such patients.

EXPERIMENTAL PROCEDURES

Both adrenalectomy and hypophysectomy are in an experimental phase of development and should not be employed generally. Investigative experience is rapidly being accumulated in large medical centers and may permit more definitive recommendations by the Committee in the future.

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* Chlorotrianisene (trichloroanisylethylene, TACE), in dosages ranging up to 96 mg. daily, was found unsatisfactory as an estrogenic mammary tumor suppressant agent, probably because its propensity for storage in fat precluded high enough blood concentrations of estrogens. Uterine bleeding was a common complication after administration of chlorotrianisene and could not be controlled by increased dosages of the agent; however, it could be controlled with diethylstilbestrol or with the other estrogens enumerated.

† The Committee has had much experience with this level of dosage. There is some evidence to suggest that a lower dosage schedule may be effective; however, experience with such lower dosage is inadequate.

REPORT OF THE COUNCIL

At the request of the Committee on Revision of the United States Pharmacopeia, the Council has reviewed the limitations specified in the Pharmacopeia as to the permissible size of containers for water for injection and for isotonic sodium chloride solution when these containers are to be used for more than one dose, that is, when the container is such that part of the content is to be withdrawn at one time, and part or parts at other times. Such containers are known as multiple-dose containers. The Council voted that its approval of the current U.S.P. practice be affirmed, and that the chairman of the subcommittee on sterile products of the U.S.P. Revision Committee be so informed. The matter had been considered previously by a panel on multiple-dose containers for the Pharmacopeia, and the Council believed that the reasoning was valid that persuaded the panel to establish the present 30 cc. limit on multiple-dose containers for these preparations.

The Council has authorized publication of the following report to explain the dangers of using water for injection or isotonic sodium chloride solution in multiple-dose containers larger than 30 cc. and without a bacteriostatic preservative.

R. T. STORMONT, M.D., *Secretary.*

WATER FOR INJECTION, U.S.P., AND ISOTONIC SODIUM CHLORIDE SOLUTION, U.S.P.

THE MULTIPLE-DOSE CONTAINER PROBLEM

Water for injection and isotonic sodium chloride solution are the official names used by the United States Pharmacopeia to describe two widely used sterile pyrogen-free preparations that serve as solvents and diluents of drugs for parenteral injection. Isotonic sodium chloride solution also is used alone as an infusion by the intravenous or by the subcutaneous route and as an irrigating fluid for wounds.

The present pharmacopeial specifications[1] for these two preparations state that a bacteriostatic agent, which is needed to help preserve sterility in a multiple-dose container, shall not be used in these two solvents or diluents, with two exceptions: a bacteriostatic agent may be used if the solvent or diluent, in a container holding not more than 100 cc., is marketed in combination with a specific medicinal preparation for parenteral administration for which it is to be the solvent; or it may be marketed alone, with a bacteriostatic preservative, if it is in a multiple-dose container of not more than 30 cc. Single-dose containers are permitted up to one liter, but these bottles for the larger infusion doses are not to contain a preservative.

These restrictions on the size of multiple-dose containers, which practically limit the number of times they can be used and consequently the chances of contamination, are in line with the progress toward increased precautions guarding the sterility and safety of injectable preparations that can be seen in each successive revision of the U. S. Pharmacopeia. At present, aside from the two considered here, 37 such preparations are restricted to single-dose containers; 45 others are allowed in multiple-dose containers, but with few exceptions these are not to exceed 30 cc. Insulin preparations must be in containers no larger than 10 cc. The use of multiple-dose containers is only for preparations that are likely to be given in a number of doses in relatively quick succession, such as in ordinary hospital or medical practice; but the tendency is toward a single-dose or separate container for each patient.

In the enforcement of the aforementioned provisions of the Pharmacopeia, the Food and Drug Administration is issuing citations against manufacturers who are distributing, not in combination with other preparations, water for injection or isotonic sodium chloride solution in containers larger than 30 cc. suitable for multiple-dose use. The claim is made that there is a definite demand for these larger containers of solvent or diluent for repeated use. The Council believes, however, that the increased hazard in repeated use from the same large container is more important than the relatively slight increased cost of the smaller containers.

1. U.S.P. XIV, pp. 546-547; 664-665 (official from Nov. 30) 1950. U.S.P. XIV, supp. 3, pp. 1, 10, 12, 13 (official from Jan. 1) 1952.

Although physicians have used multiple-dose containers of injections with apparent safety for many years, there are factors that increase the danger in the use of the larger multiple-dose containers, especially in the absence of a bacteriostatic agent. In common practice, individual doses of an injection cannot be withdrawn from a multiple-dose container without the introduction of nonsterile air. Many physicians find it expedient to inject a syringeful of air into the vial before attempting to aspirate the contents. When air is not injected deliberately, it is sucked in around the plunger of the syringe or elsewhere by the vacuum that is produced during aspiration; fine bubbles may be observed if the vial is inverted while a dose is being aspirated. The syringe and needle may be sterile, the top of the diaphragm stopper may be properly disinfected, but the air admitted to the vial is not sterile. No known bacteriostatic preservative that is innocuous to the medicament being used and to the patient receiving it can reliably maintain complete sterility. Many of the bacteria found in the soil and on the dust particles in the air grow readily in water for injection or isotonic sodium chloride solution. Co Tui and others have found that pyrogen-free distilled water usually becomes pyrogenic after standing at room temperature for 48 hours; that is, it will cause a febrile reaction when injected.

The bacteria that are commonly found in pyrogenic water belong to the Salmonella, coli-aerogenes, and Pseudomonas groups. Of these, Pseudomonas aeruginosa is very common, resistant to many antibacterial agents, and produces not only pyrogenic substances but other products of toxic nature. Pyrogenic substances may be important only when given intravenously; but toxic products may give reactions, or infections may follow from intramuscular or subcutaneous injections of small doses. In spite of the frequently demonstrable high immunity of the human body to bacteriological insult, physicians with extensive experience among diabetics are well aware of the hazards of injections.

The Council supports the policy of the United States Pharmacopeia in restricting to 30 cc. the size of multiple-dose containers of these two solvents that are intended for general use and that contain a bacteriostatic preservative and in requiring that the larger sizes of these preparations be single-dose or single-use containers, without preservative, for the following reasons: These solvents are used for dissolving or diluting many kinds of drugs; no known bacteriostatic substance is compatible with all commonly used medicaments. Some drugs are alkaline in nature, many are acidic, some are oxidizing, and some are reducing agents. Several substances that are good bacteriostatic agents in neutral or acid solutions lose all bacteriostatic effectiveness in alkaline solutions. Doses of injections in containers larger than 30 cc. usually are administered intravenously. Most bacteriostatic agents are more or less toxic when administered intravenously in large doses. In this connection it may be pointed out that phenol is much more toxic in aqueous solution than when combined in an antitoxic serum. Doses of 100 cc. of serum containing 0.5% phenol frequently have been tolerated intravenously; however, Arnold J. Lehman, chief of the division of pharmacology, Food and Drug Administration, has shown that an otherwise innocuous injection containing 0.2% phenol injected into rabbits at a dosage of 10 cc. per kilogram of body weight can cause tremors and apprehension. He also has demonstrated that an injection containing 0.5% phenol can cause severe convulsions in rabbits at a dosage of 1.7 cc. per kilogram (corresponding to 100 cc. in a man weighing 132 lb.[59.9 kg.]), and that an otherwise innocuous injection containing 0.5% chlorobutanol can cause nystagmus in test animals at a dosage of 10 cc. per kilogram.

The Council concludes that water for injection and isotonic sodium chloride solution without an adequate bacteriostatic preservative, in containers holding more than 30 cc. and under ordinary conditions of use for multiple doses, may eventually contain clinically important quantities of pyrogenic substances, toxic substances, or pathogenic bacteria. The Council also believes that the larger containers of water for injection and isotonic sodium chloride solution should be marketed as a single dose without preservative.

COUNCIL ON PHYSICAL MEDICINE AND REHABILITATION

REPORT OF THE COUNCIL

The Council has authorized publication of the following article.

RALPH E. DE FOREST, M.D., *Secretary.*

ILLEGAL OPERATION OF MEDICAL DIATHERMY EQUIPMENT

The Council on Physical Medicine and Rehabilitation of the American Medical Association brings the information in this article to the attention of the medical profession because of the urgency for complying with the regulations of the Federal Communications Commission regarding the operation of medical diathermy apparatus. In 1947 the Federal Communications Commission allowed users of the old type, nonconforming equipment to comply with the regulations within six years. This period ended on June 30, 1953. A February, 1954, Public Notice from the Federal Communications Commission stated that a number of medical diathermy machines that did not comply with the Commission's rules were still being operated by persons who either were not aware of the fact that they were violating the law or did not appreciate the importance of the reasons for the establishment of the present regulations regarding diathermy equipment.

In addition to the inconvenience caused by interference with standard radio and television broadcasts, the operation of diathermy apparatus that radiates excessively constitutes a serious potential hazard to public safety. The Federal Communications Commission Public Notice has clearly set forth the nature of these hazards. Since it has been conclusively demonstrated that both airplanes and missiles can be guided to their targets by following radio signals, it is possible that excessive radiation from nonconforming diathermy apparatus could be used by enemy aircraft as a navigational aid in flying to target areas in the United States. Diathermy apparatus that radiates excessively may interfere with radio communications. Radio is vital not only in the operation of fire and police departments but also for direct communication between airplanes and between airplanes and the ground and as a navigational aid to aircraft while in cross-country flight as well as in landing (particularly when visibility is limited).

The Council on Physical Medicine and Rehabilitation urges that the use of all old, nonconforming, non-FCC type-approved medical diathermy equipment be discontinued at once. It is urged that apparatus be operated that has been type-approved by the Federal Communications Commission and bears an FCC type approval number. This number means that the Commission's engineers have tested a prototype of the machine and have found that it complies with the requirements. Although type approval is not an absolute guarantee that the apparatus will not cause interference, it does indicate that under normal conditions of installation and operation the apparatus will not do so. As an alternative, the physician may have a competent engineer certify that an old, nonconforming type of diathermy apparatus is capable of operating in accordance with the Commission's rules; however, it is usually necessary to have a skilled engineer make extensive modifications in the device as well as carry out special field intensity tests. This procedure may prove more costly than the acquisition of an FCC type-approved machine.

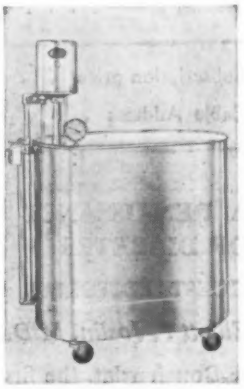
For the information of the medical profession, the Council on Physical Medicine and Rehabilitation is able to provide a list of diathermy apparatus that have met the minimal acceptance requirements for such devices established by the Council and that have been type-approved by the Federal Communications Commission.

The following additional product has been accepted as conforming to the rules of the Council on Physical Medicine and Rehabilitation of the American Medical Association for inclusion in Apparatus Accepted. A copy of the rules on which the Council bases its action will be sent on application.

RALPH E. DE FOREST, M.D., *Secretary.*

Dakon Hydrotherapy Equipment, Models AST, PST, PPT, CLS, CHS, CHP, CLP, GST-4, F-28, F-21, F-18, FH-12, FC-12, F-12, and ETE

Dakon Tool and Machine Co., Inc., 1836 Gilford Ave., New Hyde Park, N. Y.



Dakon Hydrotherapy Equipment, Models AST, PST, PPT, CLS, CHS, CHP, CLP, AST, PST, PPT, CLS, CHS, CHP, CLP, GST-4, F-28, F-21, F-18, FH-12, FC-12, F-12, and ETE

The Dakon Hydrotherapy Equipment includes the following devices:

Reference No.	Model	Description	Turbine Designation
1.	AST	Stationary arm tank	B
2.	PST	Stationary arm, leg, and hip tank	A
3.	PPT	Portable arm, leg, and hip tank	A
4.	CLS	Stationary foot tank	B
5.	CHS	Stationary foot tank	C
6.	CHP	Portable foot tank	C
7.	CLP	Portable foot tank	B
8.	GST-4	Full body hydrotherapy tank	D
9.	F-28	Portable whirlpool bath	E
10.	F-21	Portable whirlpool bath	F
11.	F-18	Portable whirlpool bath	G
12.	FH-12	Portable whirlpool bath	H
13.	FC-12	Portable whirlpool bath	H
14.	F-12	Portable whirlpool bath	H
15.	ETE	Electric turbine ejector	A

The inside dimensions of the tanks, with the capacity of each tank calculated as filled to the brim, are as follows:

Reference No.	Model	Dimensions,* Inches			Capacity			Dimensions,* Cm.		
		L.	W.	D.	Cu. In.	Gal.	Liters	L.	W.	D.
1.	AST	28	16	18	6,500	28	106	71	41	46
2.	PST	36	20	28	13,270	57	218	91	51	71
3.	PPT	36	20	28	13,270	57	218	91	51	71
4.	CLS	28	16	18	6,500	28.1	106	71	41	46
5.	CHS	28	16	21	6,570	28.4	108	71	41	53
6.	CHP	28	16	21	6,570	28.4	108	71	41	53
7.	CLP	28	16	18	6,500	28.1	106	71	41	46
8.	GST-4 (irregular in outline)									
9.	F-28	36	20	28	13,270	57	218	91	51	71
10.	F-21	28	16	21	6,570	28.4	108	71	41	53
11.	F-18	28	16	18	6,500	28.1	106	71	41	46
12.	FH-12	22	14	12.5	3,452	14.9	57	56	36	32
13.	FC-12	22	14	12.5	3,590	15.5	59	56	36	32
14.	F-12	22	14	12.5	3,590	15.5	59	56	36	32
15.	ETE (ejector)									

* L = Length; W = Width; D = Depth.

The following table gives the dimensions of the packages in which the turbines are shipped, with the power consumption for each.

Turbine	Metric Units				English Units				Power Drawn, Watts
	Height, Cm.	Length, Cm.	Width, Cm.	Weight, Kg.	Height, In.	Length, In.	Width, In.	Weight, Lb.	
A	31	122	30.5	36.3	12	48	12	80	348.5
B	31	94	31	30.4	12	37	12	67	348.5
C	31	102	31	31.8	12	40	12	70	348.5
D *	89	122	89	68	35	48	35	150	348.5
E	31	140	31	36.3	12	55	12	80	440
F	31	122	31	31.8	12	48	12	70	440
G	31	114	31	30.4	12	45	12	67	440
H	31	91	31	22.7	12	36	12	50	440

* Model GST-4 is provided with two turbines. This line gives the dimensions and weights of the package containing them both.

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A RENAISSANCE OF THE CONTROL OF DIABETES

GUEST EDITORIAL

Elliott P. Joslin, M.D., Boston

Bouchardat, the first to give hope to the diabetic, rationalized the Rollo diet, introduced exercise into diabetic care, and fixed responsibility on the patient for the control of his disease. Fanconi was sure diabetes could be controlled and to prove it even went to the extreme of the lock and key method of isolating patients. Naunyn stressed control above all else: "Each severe glycosuria in a diabetic ought to be permanently prevented, because sooner or later it will become ominous. In my experience I consider it to be very probable that among the early strictly handled patients, who in the beginning gave the impression of being severe, but later on ran a favorable course, there was many a one who has this timely rigid treatment to thank for it and, furthermore, on the other hand there can be no doubt whatsoever that the cases, which ultimately ran a severe course, in the overwhelming majority were those who were not subjected to such an energetic treatment until late if ever." These were the ideas of the leading apostles in diabetes in the last century.

Insulin arrived and diabetics lived rather than died. Coma was abolished and a coma death considered an inexcusable catastrophe. Patients treated with insulin did so much better than ever before that a relaxation in the management of the disease seemed harmless. Insulin hid the tragic symptoms and signs of the disease and thus allowed to burrow, unobserved, the slowly developing arteriosclerosis that finally killed the patient. F. M. Allen's claim, based on his work with dogs subjected to partial pancreatectomy and the results of his rigid dietetic control with humans, that progression of the disease and its complications could be prevented went for naught. The warning statistics of doctors schooled in the treatment of diabetes were decried, even though again and again they showed in statistical form that the ultimate end of the diabetic patient was governed not so much by the duration of the disease as by the type of treatment followed.

Against this background of apostasy, therefore, it is heartening now to read of the advocacy of control of the disease by those who have witnessed the results of the lack of it. Such reports stem from the Children's Hospital and the Vaxjo Hospital in Lund, Sweden, as described in Engleson's [1] monograph and in the editorials of the *British Medical Journal* [2] and *Lancet* [3] with the papers of Dunlop [4] and Matthews [5] and their colleagues from Edinburgh. All are in agreement that the easygoing treatment they have watched was followed by disastrous results and that a return to strict diabetic control is indicated. Pedersen's [6] work in Copenhagen, in which he demonstrated that the closer the control of the diabetic pregnant woman the stronger and more resistant would be her baby, also has emphasized this point. And, finally, what a testimony Diabetes Detection Week is on the part of the whole medical profession to the desirability of early control. If it is not worth while, why so much hullabaloo to try to diagnose the million unknown cases of diabetes, of which many are nearly symptomless? Should not the effort go even a step further and seek out and treat those who only have a tendency to diabetes?

What would Bouchardat, Fanconi, and Naunyn, those pioneers in diabetic treatment, say if they should be reincarnated and observe the clinical course of the average diabetic today? The disappearance of diabetic coma, still a miracle to us, would not astonish them as much as one would think, because in one way or another they all foresaw insulin. Wonder and congratulations would be expressed that now tuberculosis and infections so little hamper treatment. But imagine their amazement when they saw that patients were allowed to have glycosuria and hyperglycemia who by their methods a half-century or even a century ago would have been kept sugar free? "And yet you have insulin to help you." Better treatment of diabetes should be universal. Diabetes should be controlled. The means are at our door. We cannot afford to have 85% of our patients begin to have disease of the kidney, heart, and brain and begin to grow blind after the disease has lasted only 15 years. The treatment of the patients is not just cut and dried. It demands that the doctor sit down with the so-called brittle diabetic and every person with mild or severe diabetes, find out where the trouble is, and correct it. This always can be done. For this a young doctor has the advantage. He has more time to ferret out the cause of the disability, and if he solves the problem he has a patient for life. Fortunate is the diabetic who has a young and competent and interested physician to care for him.

More emphasis must be laid on prevention of diabetes by banishing obesity or taxing it out of existence directly or indirectly by greater restrictions in the allotment of insurance and social security benefits and by emphasizing, perhaps even ridiculing, the fashionless form of the fat female redeemed alone by her good na-

1. Engleson, G.: Studies in Diabetes Mellitus, Lund, Sweden, Berlingska Boktryckeriet, 1954; also Acta paediat. **43**: (supp. 97) (May) 1954.
2. Complications of Diabetes, editorial, Brit. M. J. **2**: 404 (Aug. 14) 1954.
3. Diet and Diabetes Complications, editorial, Lancet **2**:583 (Sept. 18) 1954.
4. Dunlop, D. M.: Are Diabetic Degenerative Complications Preventable? Brit. M. J. **2**: 383-385 (Aug. 14) 1954.
5. Matthews, J. D.: Vascular Disease in Diabetes Mellitus, Lancet **2**: 573-575 (Sept. 18) 1954.
6. Pedersen, J.: Fetal Mortality in Diabetic Pregnancies, Diabetes **3**: 199-204 (May-June) 1954.

ture.[7] Rules for marriage should be tightened so as to lessen the influence of heredity. All glycosurias of pregnant women should be treated and even their tendencies to diabetes, elicited by glucose tolerance tests during pregnancy, attacked so actively with diet and insulin that the development of the disease in mother and offspring may be averted, as suggested by Hoet's experiments with animals.

Errors in the diagnosis of diabetes will be acknowledged by any clinician who follows the subsequent course in his patients for a series of years. It may be only one case in 100, but such cases are important, although troublesome in compiling statistics. These are the cases that fan the spark of hope that both doctor and patient need. As yet I have not considered it right to say that the reason for the change in diagnosis is due to the cure of diabetes, but I wonder if it is not justifiable to conclude that through early recognition of glycosuria and hyperglycemia in a person, their prompt correction, and the institution of suitable rules of life one may have deferred the onset of the disease for years or a lifetime. We know there are mild cases of undoubted diabetes that yield to treatment and do well for decades. Is it not conceivable that there is another, still milder group in which the outbreak of symptoms may have been postponed? Bouchardat brought hope to the diabetic and really felt that diabetes could be cured. His words were, " . . . all my efforts have been concentrated upon one end—to cure a disease judged incurable by all good observers who have patiently followed up their cases."

For more than half a century I have been so impressed and guided by Naunyn's attitude toward diabetes and his program for its treatment that once more I am quoting it here, because today, as 50 years ago, there is far too much nursing and far too little doctoring of the diabetic. He wrote, "I consider it a pessimistic limitation of the task obligatory upon the doctor in the treatment of the diabetic when it is said, 'The essential duty of the doctor is and remains to keep the patient alive for a long time in a tolerable condition.' According to my view there is often included in the treatment a broader and more definite purpose, namely this—to strengthen (to better) the disturbed function or at least to halt its further deterioration (the progressive development of the disease)." It may be true that only one in 10 of our patients is now eligible for a life expectancy medal for living longer with diabetes than expected to live without it and that only 54 in the world have been recognized as perfect after 25 years of the disease, but surely we doctors should be able to postpone the onset of complications until after 15 years in more than 15% of our cases. We should strive to have our patients live longer with the disease than the average nondiabetic person, because our group of patients is the one most under the doctor's eye. If we do not make them live longer, then the argument for routine health examinations falls flat.

7. Joslin, E. P.: The Prevention of Diabetes Mellitus, J. A. M. A. 76: 79-84 (Jan. 8) 1921.

FIFTEENTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH

Few aspects in the current scene are of more long-range importance to the medical profession than the problems associated with the provision of health services and medical care programs to industrial workers. The Council on Industrial Health and the Council on Medical Service are both vitally concerned and have appointed a joint committee to keep abreast of developments and to alert the profession at large about the role of medicine in an industrial society. This, in effect, is the general theme of the 15th Annual Congress on Industrial Health, which will take place at the Shoreham Hotel in Washington, D. C., on Jan. 25-26, 1955. The preliminary program appears in this issue of THE JOURNAL.

Nearly everyone is agreed that expansion of preventive medicine in industry should be actively encouraged, based on understanding and cooperation between plant physicians, private practitioners, and community health services. One section of the congress will concern itself with these interrelationships as an important contribution to community and personal health. The ultimate role that industrial medicine should play must depend upon recurrent evaluations of the actual health status of the working population and a reassessment of the record of accomplishment of those professional groups directly concerned. Of even greater importance is the necessity for opening up channels of communication between labor, management, and medicine if absenteeism and costs of illness are to become fixed charges in industry.

Another section of the congress will devote itself to workmen's compensation, an area of uncommon interest at the moment. Interviews will be arranged with representatives of management, labor, insurance, law, administration, and medicine to define professional relations, both in terms of specific services and of the broader implications of rehabilitation, residual ability, and productive employment.

A third section, arranged in cooperation with the division of biology and medicine of the Atomic Energy Commission, will direct attention to fundamental issues created by the transition of the atomic energy industry from governmental to private auspices. The selection of sites for atomic reactors will constitute community health problems of first magnitude. There are equally important and far-reaching considerations surrounding the use of isotopes in industry, in radiochemical processing establishments, and in medical practice. There have been voices crying for years for better correlation between industrial research and the delineation of potential health hazards. The successful record of the AEC convincingly demonstrates the advantage of foresight and planning.

As usual, a special effort is being made to attract attendance from the state medical societies, especially the appointed committees on industrial health. Selection of Washington as a site for the congress was in part an attempt to provide an opportunity to observe the programs of federal agencies in this general area at close range. The Shoreham is holding space for those requesting reservations for the meeting. Those who expect to attend should make their reservations directly with the Shoreham Hotel.

THE INTERNATIONAL SURGEONS' HALL OF FAME

A new institution is developing on Chicago's near north side that will be of great interest to the medical profession throughout the world. It is the International Surgeons' Hall of Fame and Museum of Surgical Science. This unique organization was conceived to recognize the contributions of surgeons to freedom from suffering, to the prolongation of life, and to the progress of mankind. While it was dedicated only last September at a ceremony attended by representatives from many countries, rapid progress has been made in remodeling the attractive building and in the installation of the priceless exhibits. The idea and the hope for a surgeon's shrine and museum originated years ago with Dr. Max Thorek, founder of the International College of Surgeons, but not until 1953 did the trustees of the college act to establish the memorial. A mansion adjoining the headquarters of the college was purchased, and architects were promptly commissioned to supervise the necessary remodeling. In September of 1953, an international committee on arrangements was appointed, with Dr. Rudolf Nissen of Switzerland and Dr. Morris Fishbein of Chicago as co-chairmen. By March a distinguished Italian painter had finished sketches for the mural room depicting the development of surgical science throughout the ages, and many of the murals have now been completed. Sculptors from the Chicago Art Institute were commissioned to create life-sized figures of the immortals who will occupy the room by that name, and one of these statues has already been installed. The 12 were selected by an international committee of surgeons and medical historians. They are Imhotep, Hippocrates, Galen, Ambroise Paré, Vesalius, William Harvey, Giovanni Battista Morgagni, Ignaz Philipp Semmelweis, Louis Pasteur, Joseph Lister, Wilhelm von Roentgen, and Marie Curie.

Many countries or groups of countries have been assigned their own rooms in the Hall of Fame, and among the rooms already furnished or partly so are those of Argentina, Austria, Brazil, British Commonwealth, China, Colombia, Egypt, France, Greece, Haiti, India, Israel, Italy, Japan, Mexico, Netherlands, Peru, Scandinavia, Switzerland, Turkey, United States, Venezuela. Others will be added shortly. The few exceptional treasures on display that can be mentioned here include the original postmortem report on the body of President Lincoln, the original mask used in administering the first anesthetic, 50 letters of Florence Nightingale, and the original model of the Carrel-Lindbergh artificial heart, which was installed in the Hall of Fame by General Lindbergh himself. Another room is the Hall of Manuscripts, which has been enriched by Dr. Thorek's own collection of scientific papers, the massing of which has been a hobby of his for many years. These will be greatly augmented by other persons and institutions interested in medical history.

A significant idea yet to be realized is the remodeling of the building in the rear of the Hall of Fame into an amphitheater where series of lectures by eminent speakers will be presented periodically to medical students, physicians, and the public. On the lawn along Lake Shore Drive will be erected a life-sized statue symbolizing the surgeon rendering aid to a stricken patient.

While a memorial so extensive and far reaching cannot be wholly achieved in a day, the cooperation and support already given by many nations and individuals strongly indicate a genuine desire and need for continued progress. Last September 9 at the dedication banquet delegates from 25 countries were present.

The International Surgeons' Hall of Fame will be controlled by an electoral college of about 150 members and by the international officers of the International College of Surgeons. The college of electors will include one from each section of the International College of Surgeons and one from each nation in which no section exists chosen by the surgical organizations of such nations. Nominations for the Hall of Fame are not restricted to member nations. The electoral college will consider the merits of any nominee suggested by any surgeon in the world; however, no name will be recognized for this distinction except that of a person who has been deceased for at least 15 years.

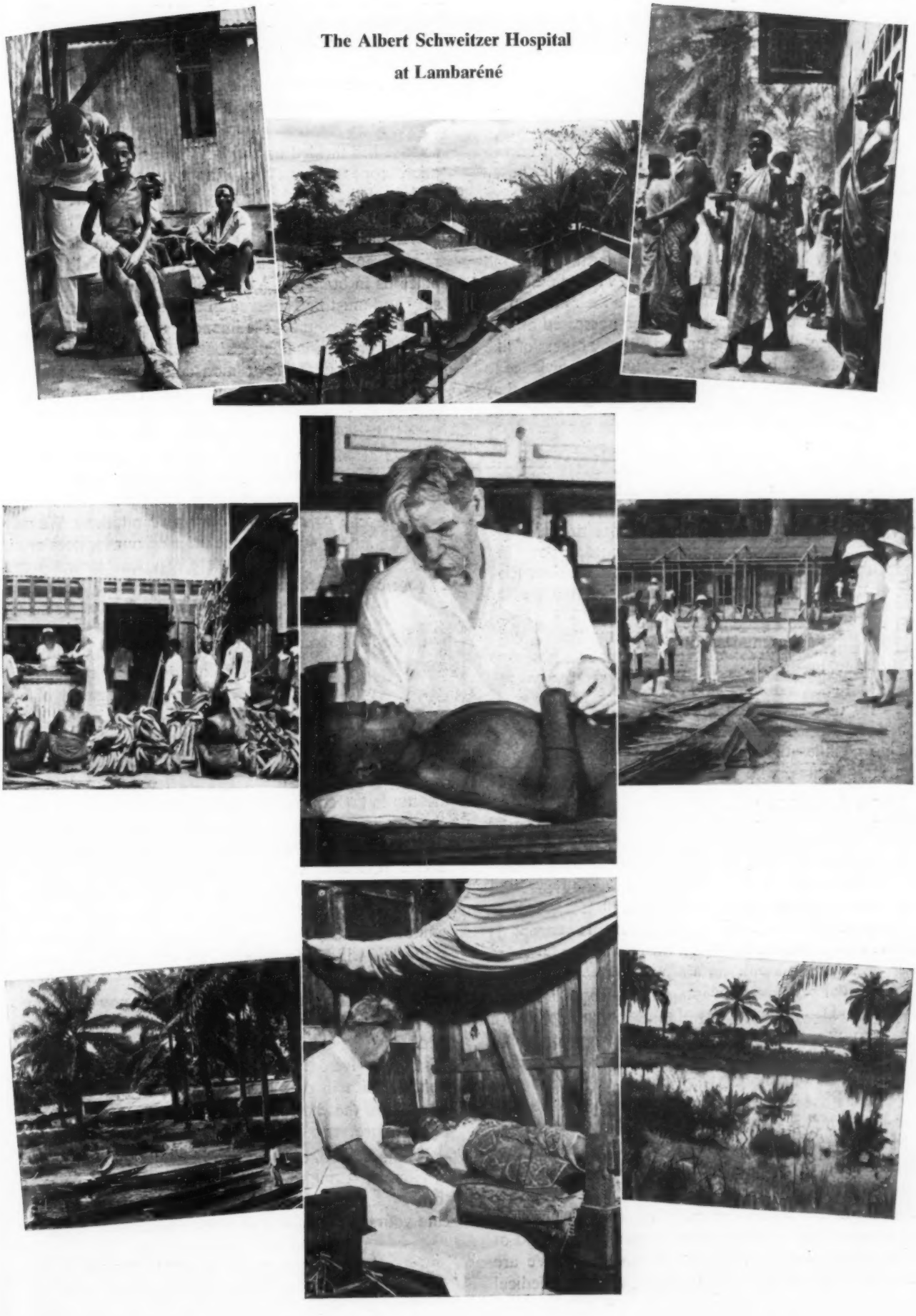
And so, as others have said of this memorial, "We are but paying another installment of our agelong debt to those who cleared the way for us, a debt to which we can never write 'paid in full.' Without the heritage of knowledge and skill bequeathed us by the genius of the past, the genius of the future would be but a flickering torch."

ALBERT SCHWEITZER, DOCTOR

THE JOURNAL of the American Medical Association is honored in presenting an article by Albert Schweitzer in this issue. Dr. Schweitzer is known throughout the world for his interests in music, theology, philosophy, and medicine. His Nobel peace prize of 1952, which was presented to him in 1954, is another reminder of the deserved recognition given to this man. Unselfish and studious, hard-working and thoughtful, teacher and healer—this is Albert Schweitzer. The possessor of many degrees, earned and honorary, he exemplifies the word "doctor" in its broadest connotation. In 1949 THE JOURNAL commented editorially on Dr. Schweitzer. At that time the doctor was being honored by many groups for his various accomplishments. The editorial reads in part: "Eminent as an authority on Goethe and Bach and as a scholar for his interpretation of religion, Dr. Schweitzer also is well known as a physician who for over 30 years has treated the sick in French Equatorial Africa. . . . The medical profession is proud of Dr. Albert Schweitzer. His actions have revealed more clearly than words that the motivating force of his life has been service to humanity."

In 1955 Dr. Schweitzer will be 80 years of age. To commemorate this, friends and supporters have organized the Albert Schweitzer Hospital Fund to raise funds for use at the hospital at Lambaréné. Those who contribute can claim tax exemptions for the gifts and may send their donations to the fund at 34 E. 51st St., New York 22, N. Y. Dr. Schweitzer has used his Nobel peace prize of more than $30,000 for corrugated iron roofs for hospital buildings at Lambaréné. No one needs to be told of the good that will come of money given to the fund, but a glimpse of "jungle medicine" is given in the picture on page 1587 of this issue.

The Albert Schweitzer Hospital at Lambaréné



THE PRESIDENT'S PAGE

A MONTHLY MESSAGE

Physicians like physicists, as they advance in knowledge, acquire power that if not rightly used or if abused becomes dangerous rather than beneficial to their fellow men. They are members of groups so far removed from current thought by reason of their technical knowledge that they may be objects of veneration on the one hand or of fear and hatred on the other. If they do win the confidence of the people, they may also gain their admiration or even their love and devotion. Being possessed of special knowledge, they can be judged only by others of like learning as to how honestly they apply this knowledge to the benefit of mankind or be justly condemned if they prostitute their profession or change the "temple" into a commercial forum.

The quack, the charlatan, and the conscienceless uninstructed may prey on the ignorant and the hapless as long as they can shine in the glory of the real scientist or physician or impose on the people a belief in their competency in the field of health Even the elect among those who possess true knowledge may become callous or over-ambitious and pervert their high calling for selfish and venial purposes.

Medicine in its beginning was closely allied to the priesthood, and now more than ever this association should be reaffirmed. It is not by chance that the code that now guides the physician originated with Hippocrates, who was also the first to lay down the principles that underlie modern scientific medicine. Hippocrates must have realized that he who enters the temple of Aesculapius must at that time subscribe to an oath to the effect that he will not corruptly use the knowledge, opportunities, and advantages that may be his by reason of being a physician.

Our code of ethics is an outgrowth of this concept. It was not designed for our protection. It was not intended to hedge us around with certain immunities nor to give us a particular economic advantage. Its purpose is to protect mankind from the tyranny of authority and to govern those who by reason of special knowledge are somewhat above the law. We tremble now as a people when we consider the power of the nuclear physicist. We hope that he may save us but fear that he may destroy us. Is he controlled by a higher law than the laws of physics, or can he be corrupted by our enemies? We fear him because there are none among us who can look beyond the bounds of his knowledge.

Physicians are somewhat similarly placed, since they have had technical and scientific training in the field of health beyond that of the general population. We are also under suspicion. The forward surge of medical science has thrilled us and inspired us. We look into the microscopes and test tubes and may see the medical salvation of the world. We may forget, however, that the higher we are on Olympus the more we may be feared and the less we may be loved. The politician close to the people senses this distrust and at times would seek to place us in bondage. A code of medical ethics is necessary and must be observed in its true meaning if we are to survive unbound. It is intended to point out a way of life for professional men that will leave medicine unhampered by undue restrictions and regulations and that will preserve for us the confidence of the people. This confidence is always threatened by the very fact of the special knowledge that we possess. We may claim more than we actually have. Behind the cloak of our profession, we may take advantage of our patient's ignorance and perhaps not acknowledge our own limitations. We may place an undue price on our services or we may render these services carelessly and inefficiently. We may hold forth special promises or pretend to skills that we do not possess. We may sell our services in a market place where we know the quality will depreciate. We may consider our comfort and our ease beyond the necessity of our patient.

The paragraphs in our code should not be considered as regulations but as guides to conduct, which, if observed, will contribute to the advancement of medicine and will work to the best interests of our patients. Advertising, withholding of information, patents, commercial rebates, collusion, secret remedies, dogmas, and commercialism are not empty phrases but relate to things that not only will destroy our own character but if indulged in generally will undermine public confidence to an extent that medicine itself will be destroyed. This applies to medicine as a whole and it applies to medicine as practiced by us as individuals. The art of medicine, that powerful handmaiden of science, will sicken and perish in an atmosphere of distrust. As individuals, as a society, and as a fraternity, we can survive only by maintaining among the people an abiding faith in our integrity and our devotion to the interests of those whose welfare we have solemnly undertaken to protect.

At this season, devoted to a remembrance of the birth of Him who came to bring justice, mercy, and peace into the world, I ask you of American medicine to again dedicate yourselves to the high purposes of our calling.

Walter B. Martin, M.D.,
Norfolk, Va.

ORGANIZATION SECTION

FIFTEENTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH

Shoreham Hotel, Washington, D. C.

Jan. 25-26, 1955

Sponsored by
The Council on Industrial Health of the American Medical Association
and
The Medical Society of the District of Columbia

Sessions are open to physicians and others interested in industrial health

PRELIMINARY PROGRAM

TUESDAY MORNING, JAN. 25

OPENING GENERAL SESSION

WILLIAM P. SHEPARD, M.D., New York, *Presiding*
Chairman, Council on Industrial Health

Medicine in an Industrial Society

STAFFORD L. WARREN, M.D.
Dean, School of Medicine, University of California Medical Center, Los Angeles
Discussion:
Labor:
A. J. HAYES, Washington, D. C., President, International Association of Machinists
Management:
Speaker to be announced
Official Health Agency:
LEONARD A. SCHEELE, M.D., Washington, D. C., Surgeon General, U. S. Public Health Service
Medicine:
WALTER B. MARTIN, M.D., Norfolk, Va.
President, American Medical Association

Summary

Announcements
Instruction on Panel Procedure

PANEL I. OCCUPATIONAL HEALTH—A MAJOR CONTRIBUTOR TO COMMUNITY AND PERSONAL HEALTH

Arranged with the Advisory Committee to the Public Health Service on Occupational Health

Participants:

JUSTIN M. ANDREWS
Associate Chief for Program, Bureau of State Services, Washington, D. C.
DANIEL J. BERGSMA, M.D.
State Commissioner of Health, New Jersey Department of Health, Trenton
LEROY E. BURNEY, M.D.
Deputy Bureau Chief, Bureau of State Services, Washington, D. C.
ALBERT J. HAYES
President, International Association of Machinists, Washington, D. C.
HOWARD R. HUSTON
Vice President, American Cyanamid Co., New York
ROBERT A. KEHOE, M.D.
Director, Kettering Laboratory, University of Cincinnati, Cincinnati
MISS MARION E. MARTIN
Commissioner, Department of Labor and Industry, Augusta, Maine
T. MARCUS MCCLELLAN
President, Birmingham Paper Co., Birmingham, Ala.
HARRY C. READ
Executive Assistant to the Secretary-Treasurer, Congress of Industrial Organizations, Washington, D. C.
WILLIAM A. SAWYER, M.D.
Industrial Medical Consultant, Rochester, N. Y.
MRS. MILDRED DUNN THOMAS
Supervisor, Nursing Service, Merck & Company, Inc., Rahway, N. J.
WILLIAM P. YANT
Director of Research and Development, Mine Safety Appliances Company, Pittsburgh

SESSION 1. TUESDAY AFTERNOON, JAN. 25

MELVIN N. NEWQUIST, M.D., New York, *Presiding*
Chairman, Committee on Public Services
Council on Industrial Health

Status of Health of the Working Population—What Is Needed by the Professions Involved to Do a Better Job

Safety
Environmental Hygiene
Industrial Medicine
Industrial Nursing
Health Agencies
Summary

SESSION 2. WEDNESDAY MORNING, JAN. 26

WILLIAM P. SHEPARD, M.D., New York, *Presiding*
Chairman, Council on Industrial Health
and
JOSEPH D. MCCARTHY, M.D., Omaha, *Presiding*
Chairman, Council on Medical Service

Program arranged jointly by the Council on Industrial Health and the Council on Medical Service

Industrial Medicine and the Economics of Medical Care

Trends in Medical Benefit Negotiations
Effects of These Trends on Private and Industrial Medical Practice
Workmen's Compensation Experience as a Guide to the Extension of Medical Benefits
Effects of Prevention in Industry on Medical Care Programs

SESSION 3. WEDNESDAY AFTERNOON, JAN. 26

ELMER HESS, M.D., Erie, Pa., *Presiding*
President-Elect, American Medical Association

Improving Communications Between Medicine, Management, and Labor in Relation to:

Industrial Medicine
General Health Care

PANEL II. THE IMPACT OF THE ATOMIC ENERGY INDUSTRY ON COMMUNITY HEALTH

Program arranged in cooperation with the Division of Biology and Medicine, Atomic Energy Commission

Participants:

ROY E. ALBERT, M.D.
Division of Biology and Medicine, AEC
JOHN BUGHER, M.D.
Director of the Division of Biology and Medicine, AEC
CHARLES L. DUNHAM, M.D.
Deputy Director, Division of Biology and Medicine, AEC
W. K. DAVIS
Assistant Director, Division of Reactor Development, AEC
DUNCAN A. HOLADAY
U. S. Public Health Service
GEORGE G. MANOV
Office of Industrial Development, AEC
HERBERT M. PARKER
Director, Radiological Sciences Department, General Electric Company, Hanford Atomic Products Division
JOHN ROBINSON
Assistant Director, Engineering Division of Reactor Development, AEC
JAMES H. STERNER, M.D.
Medical Director, Eastman Kodak Co., Rochester, N. Y.
ROBERT M. TAYLOR, M.D.
Director, Medical Division, Atomic Energy of Canada, Ltd., Chalk River Project

JAMES G. TERRILL
U. S. Public Health Service
FORREST WESTERN
Division of Biology and Medicine, AEC

SESSION 1. TUESDAY AFTERNOON, JAN. 25

JOHN BUGHER, M.D., Washington, D. C., *Presiding*

Review of Health Problems in the Atomic Energy Industry

Description of Power Reactors—Criteria for Site Selection
Hazards in Normal Operating Conditions in the Plant and in the Community
Organization and Functions of Industrial Hygiene and Radiological Physics Groups
Industrial Medicine and the Reactor Program
Responsibility of Public Health Agencies in Monitoring and Control
Summary

SESSION 2. WEDNESDAY MORNING, JAN. 26

CHARLES L. DUNHAM, M.D., Washington, D. C., *Presiding*

Disasters—Nature and Likelihood in Power Reactor Operation

Effects of Accidents on Plant and Community
Techniques and Problems of Decontamination
Organization of Disaster Plan in the Plant
Relation of Plan to Community Program
Medical Problems and Treatment
Role of the Public Health Services in Accidents Related to Power Reactor Operations
Summary

SESSION 3. WEDNESDAY AFTERNOON, JAN. 26

JOHN BUGHER, M.D., *Presiding*

Health Problems:

In the Use of Isotopes in Industry
In the Radio Chemical Processing Industry
In the Use of Isotopes in Medical and Hospital Practice

Health and Safety Problems Associated with the Transition of the Atomic Energy Industry from Government to Private Control, with Special Reference to:

Licensing by the Atomic Energy Commission
Cost Factors in the Interpretation of Current Maximum Permissible Tolerance Levels for Exposure to Radiation

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PANEL III. THE CHALLENGE OF OCCUPATIONAL DISABILITY

HENRY H. KESSLER, M.D., Newark, N. J., *Presiding*
Chairman, Committee on Workmen's Compensation
Council on Industrial Health

Committee Members:
LLOYD E. HAMLIN, M.D., Chicago
E. S. JONES, M.D., Hammond, Ind.
RUTHERFORD T. JOHNSTONE, M.D., Los Angeles
HENRY H. KESSLER, M.D., Newark, N. J.
O. A. SANDER, M.D., Milwaukee

Consultants:
EARL F. CHEIT, St. Louis
BERNARD D. HIRSH, Chicago
JAMES J. REID, Greenville, S. C.
HERMAN M. SOMERS, Haverford, Pa.

National agencies representing management, labor, insurance, law and the health professions will present their views on the essentials and goals of a desirable modern workmen's compensation program. The panel is designed to aid in the development of an effective program for the medical profession, both as physicians and as citizens in an industrial society.

SESSION 1. TUESDAY AFTERNOON, JAN. 25
SESSION 2. WEDNESDAY MORNING, JAN. 26
SESSION 3. WEDNESDAY AFTERNOON, JAN. 26

TUESDAY EVENING, JAN. 25
ANNUAL DINNER

With the Medical Society of the District of Columbia and the Washington Board of Trade.

Physicians Award for 1954—To Physician Making an Outstanding Contribution to the Employment Welfare of the Handicapped.

Conserving the Health of Executives
Speaker to be announced

PRECONVENTION AND POSTCONVENTION TOURS TO EUROPE

Air tours of Europe, sponsored by the American Medical Association and operated by United Air Lines in conjunction with Thomas Cook & Son, have been arranged to precede and follow the Annual Meeting at Atlantic City, N. J., June 6-10, 1955. Physicians and their wives have a choice of four itineraries, each of four weeks' duration. Departures from New York are scheduled for May 6, May 8, June 11, and June 13. Deluxe air service will be provided by Air France, British Overseas Airways Corp., KLM Royal Dutch, Pan American, Sabena Belgian, Scandinavian Airlines System, and Swissair airlines.

In addition to sojourns at capital cities and renowned "Old-World" resorts, the tours will include meetings in London, Paris, and Zurich at which eminent European scientists will lecture. Concurrent with the medical meetings, style shows will be presented in these cities and Rome for the distaff side. Among the cities to be visted on the preconvention tours, departing May 6 and 8, are London, Amsterdam, Haarlem, The Hague, Coblenz, Frankfurt, Zurich, Lucerne, Milan, Venice, Florence, Rome, Genoa, Monte Carlo, Grasse, Nice, and Paris. Surface transportation will include motor coach, a Rhine steamer, and gondolas in Venice. Accommodations on the "Blue Train," celebrated as offering the utmost in luxurious rail travel, will be provided between Nice and Paris. Points of interest on the itinerary range from the Tower of London to the Palace of the Doges. A partial listing follows:

Arc de Triomphe, Paris.

Stoke Poges, Windsor Castle, Eton College, Hampton Court Palace, Westminster Abbey, Rembrandt's house, the Isle of Marken, the Aalsmeer flower market, St. Marks, the Pitti Palace, the Ponte Vecchio, the Colosseum, the Pantheon, the Sistine Chapel, the Louvre museum, the Ecole des Beaux-Arts, Notre Dame Cathedral, Napoleon's tomb, the Tuileries gardens, the palace of Versailles, and the Eiffel Tower.

Those enplaning on May 6 will return to New York on June 3; those enplaning on May 8 will return June 5. Postconvention tours, departing on June 11 and June 13, are generally similar to the earlier tours. Both include medical meetings and style shows. Itineraries encompass the cities and points of interest described. The cost of each tour is $1,598, which covers round-trip transportation, all enroute meals, and hotel accommodations. A deposit of $100 is required at the time of booking. Checks should be drawn to the order of United Air Lines for both the deposit and final payment, due April 8.

Those contemplating either a preconvention or a postconvention tour are urged to respond early so that final arrangements can be completed well in advance of departure dates. A tour folder with the official application blank attached will be mailed to all A. M. A members in January. Requests for bookings or additional information should be addressed to: American Medical Association, Pre- and Post-Convention Tours, 5959 S. Cicero Ave., Chicago 38, Ill.

PROCEEDINGS OF THE MIAMI CLINICAL MEETING

ABSTRACT OF PROCEEDINGS OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION AT THE CLINICAL MEETING IN MIAMI, FLA., NOV. 29-DEC. 2, 1954

The actions of the House of Delegates at the Miami Meeting are herewith abstracted so that the readers may have this information in digest form. The official proceedings will be made available, as in the past, in a booklet, which will be sent to all members of the House of Delegates and officers of the American Medical Association by the Secretary. This booklet will not be available for several weeks.—ED.

Invocation

Dr. Lowry H. McDaniel, Arkansas, pronounced the following invocation:

Our Father in Heaven, we thank Thee that we are disciples of the Great Physician. May nothing be done or said at this meeting which would detract from this ideal that we men of medicine have. Wilt Thou go with us throughout our deliberations of the entire meeting, that much good may be done for suffering humanity because of our efforts. We ask it in Christ's name. Amen.

Preliminary Report of Reference Committee on Credentials

Dr. Walter E. Vest, Chairman, reported that 178 delegates had been seated, and the Speaker announced that a quorum was present.

General Practitioner of the Year

Dr. Dwight H. Murray, Chairman, Board of Trustees, made the following announcement:

In accordance with established rule, a special committee was appointed to consider the nominations for the General Practitioner's award. Pursuant to its recommendations, the Board of Trustees is happy to announce the selection of Dr. Karl B. Pace of Greenville, N. C., as the General Practitioner of the Year.

Presentation of Medal to General Practitioner of the Year

Dr. Walter B. Martin, President, presented the General Practitioner gold medal award to Dr. Karl B. Pace, Greenville, N. C., with the following remarks:

Dr. Karl B. Pace, who is 66, has been practicing in Greenville since 1914. He and three other physicians, starting in 1916, led a movement to build the first hospital in their county, which was completed in 1923. He has served as a director of the Red Cross, on the board of directors of the Boy Scouts, and as a director of the Chamber of Commerce; has helped organize the Pitt County Executives Club; and was president of the Rotary Club in 1930. He was one of the organizers of the Greenville American Legion Post and one of its early commanders. He was a member of the official board of the Jarvis Memorial Methodist Church for 30 years and chairman of its finance committee for 25 years. He was a director of the State Bank and Trust Company for 15 years and served as chairman of the Greenville Utilities Commission for a number of years. Besides these community endeavors, Dr. Pace in 1920 was the leader in reorganization of the Pitt County Medical Society, was a member of the Society of North Carolina Board of Medical Examiners from 1938 through 1944, served as president of the Tri-State Medical Society and as head of the Atlantic Coast Line Surgeons Association, and is a member of the Seaboard Medical Society. Dr. Pace was on the original committee to reorganize the medical college at the University of North Carolina, which led to creation of a full four-year medical school for the state. In 1920 he started the first venereal disease clinic in North Carolina. Dr. Pace received his doctor of medicine degree in 1914 from the Jefferson Medical College, and after serving as an intern at Gouverneur Hospital in New York and at Nassau Hospital in Mineola, N. Y., during 1914 to 1916 he returned to North Carolina and became associated with Dr. C. H. O. Laughinghouse at Greenville. Except for duty during World War I in Europe as commander of a hospital train, Dr. Pace has spent the rest of his practice in Greenville. He was married in 1922 and has three sons; two of them are physicians and the third recently completed his senior year at the University of North Carolina.

Dr. Pace, throughout your professional life you have exemplified the highest traditions of medicine. You have served your community, state, and nation as a practitioner of medicine, in civic affairs, in the field of education, and in war. By reason of these many contributions you are deemed most worthy of this high honor conferred on you by your fellow physicians acting through our national body, the American Medical Association.

Dr. Pace accepted the medal with remarks as follows:

Mr. Speaker, Members of the House of Delegates, Ladies and Gentlemen: Being a country doctor, you know without my telling you that I am scared to death. If you feel the building shaking, don't think it is Hurricane Hazel; it is my knees. All through my life I have had the great pleasure of doing things for other people rather than for myself. I had not the least idea of ever getting this award. Wherever it may have come from, even though it be misplaced and should have gone to someone else, I am quite sure I do appreciate it. I think that everything that happens must have some cause, and everything that I am or ever hope to be I owe to my mother, whose motto was doing something for others rather than yourself. In living this life of ours, we go through here but once. No matter whether you are 9 or 90, it is a short time compared with the hereafter, and we should do everything we can in our lives to prepare for that hereafter. I have had fun all through my life. Many people say, with the many outside activities in which I have engaged, they don't see how I ever found time to practice medicine. Well, I have practiced medicine in my spare time. Thank you!

Report of Reference Committee on Rules and Order of Business

Dr. William H. Halley, Chairman, presented the following report, which was adopted:

Your Reference Committee on Rules and Order of Business recommends: (1) that, during this session, the order of business as mimeographed be approved, and that the Speaker be empowered to make such changes in the order of business as, in his judgment, will facilitate the transaction of the business of the House; (2) that the Speaker be granted permission and the privilege of delegating that permission to introduce to the House distinguished guests and other persons who may have messages of interest and importance; and (3) that the Speaker be empowered to recess the House and to call it back into session at his discretion.

Adoption of Minutes of San Francisco Annual Meeting

The minutes of the annual meeting held in San Francisco, June 21 to 25, 1954, were adopted as printed and distributed to the members of the House of Delegates.

Remarks of the Speaker, Dr. James R. Reuling

The Speaker presented the following remarks, which were referred to the Reference Committee on Reports of Officers:

Members of the House of Delegates of the American Medical Association: I wish at the outset to express my deep appreciation to all of you who have cooperated by getting so many resolutions submitted in advance. You will find in your folders a copy of the detailed order of business, which apparently meets with your approval, as you have already acted on the report of that reference committee. At this time I would like to suggest that you put your name, your hotel and room number, as well as your home address on the outside of the folder, so that if it is in-

advertently left or mislaid it will find its way back to you. Next in your folder you will find lists of matters referred from the Handbook. The first one of these is a list of references by consecutive pages as they are numbered in the Handbook. The other lists, headed by the names of the various reference commitees, are cross references of matters referred to the individual committees, containing the subject matters, as well as the pages on which they appear in the Handbook. Material received from the Board of Trustees which is not printed in the Handbook you will find in your folders, and these reports will always be indicated by capital letters A, B, C, etc., in contradistinction to resolutions from constituent associations or individual delegates, which bear numbers 1, 2, 3, etc. These numbers have been and will be assigned in the order in which resolutions are received for mimeographing. Likewise, when we reach new business on the order of business, resolutions will be presented in their proper numerical order.

A suggestion which your Speaker received from one of the large states, and which he feels has great merit, was to the effect that a copy of the Handbook be sent to all alternate delegates. There is a great variation among the several states regarding their alternates' attendance at the meetings of the House of Delegates. From some states they all attend every meeting, and in the case of other states the alternates never attend. I would suggest, therefore, that in the future the secretaries of those state societies which require their alternate delegates to attend meetings request the headquarters office to put their alternate delegates on the mailing list to receive the Handbook, in addition to their delegates. We have a few extra copies of the Handbook here, and, if there are alternates present who wish copies, they may obtain them while the supply lasts by showing their badges at the Secretary's office.

REFERENCE COMMITTEES

At the risk of repetition, the following procedure will be followed by all committees to which references are made:

The chairman of a reference committee will first organize his committee and determine in what order it will hear referred matters. He then will write this information on the blackboard in his committee room. When hearings have been completed on the first subject, a line will be drawn through that item. It is not to be erased. The purpose of this procedure is to let all delegates know when subjects that they may be interested in have been heard or the approximate time they will be reached. Committee meetings will be held at the time and in the room assigned. If any deviation is made, a notice will be left in the assigned room advising where the chairman may be reached, or, if the meeting is transferred to another room or adjourned to another time, the notice will give you all necessary information; also the Secretary or Assistant Secretary and the Speaker or Vice-Speaker will be notified of the change.

Reference committees will hear any member of the Association who wishes to appear before them, whether he is a delegate or not. The committees may hear individuals who are not members of the Association. Reference committees may, at the chairman's discretion, go into executive session for the purpose of hearing any individual or group of individuals. Members of the headquarters staff and councils should be utilized to the fullest extent for information. This may relate to actions of previous Houses that have considered similar matters or any other pertinent material. General officers and members of the Board of Trustees should be requested to appear before a committee when necessary. Since they have many commitments, their appearance should be by appointment if possible.

If any matters are referred to a committee which, in its opinion, do not properly belong in that committee for consideration, do not make any re-referrals yourself. Advise the Speaker, or the Vice-Speaker, who will make the decision as to re-referrals. This must be done in order that all records are kept in proper order.

PREPARATION OF REPORTS

The report of each reference committee should be prepared without having any strongly partisan individuals present and preferably in executive session. Four copies of the reference committee reports must be presented to the Secretary. It is desirable that all members of the committee sign the original and first copy of the report, but in no event can a report be accepted without a majority signing. If a reference committee cannot reach a unanimous opinion, a minority report should be submitted. The individual or individuals making a minority report should refrain from signing a majority report.

Again, attention is called to the fact that the resolutions in your folder should be considered confidential information. They do not constitute any action of this House of Delegates or policy of the American Medical Association.

Please sign your attendance slips each day before you enter the House. Please wear your badges on the right lapel.

The composition of the various reference committees has been published in THE JOURNAL (Oct. 30, 1954, page 845), and these lists also appear in your Handbook. The only changes from the published list are as follows: On the Reference Committee on Legislation and Public Relations, Dr. John F. Burton, Oklahoma, in place of Dr. James Stevenson, Oklahoma; on the Reference Committee on Rules and Order of Business, Dr. Laurence S. Nelson Sr., Kansas, in place of Dr. George F. Gsell, Kansas; on the Reference Committee on Hygiene, Public Health, and Industrial Health, Dr. Lowry H. McDaniel, Arkansas, in place of Dr. R. B. Robins, Arkansas; and on the Reference Committee on Miscellaneous Business, Dr. L. Howard Schriver, Ohio, in place of Dr. George A. Woodhouse, Ohio.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

Dr. Warren W. Furey, Chairman, presented the following report, which was adopted:

Address of the Speaker, Dr. James R. Reuling: The high position in which our Speaker and Vice-Speaker are held by the delegates was well demonstrated by the spontaneous and enthusiastic response of this House in unanimously adopting without reference a resolution commending the services of these able officers. Your reference committee would like to add a few orchids to the bouquet by voicing the opinion that the Speaker and the Vice-Speaker are deserving of high praise for their continuing effort to improve the rules and order of procedure followed by the House. The many innovations introduced during their tenure, including mimeographing and distribution of resolutions and of other material for the delegates, the provision of tables for delegates, and the instructions to delegates contained in the booklet "Your Role as a Delegate," to mention just a few, have greatly facilitated and improved the method of doing business.

In line with these innovations, your reference committee strongly recommends that, whenever possible, resolutions be submitted at an early date to aid in the more efficient consideration and disposition of business. It should be recognized, however, that many items of current interest and concern might be unnecessarily delayed if a hard and fast deadline were established for introduction of new business.

At the suggestion of those participating in the deliberations of the hearing, your committee recommends to the editors of THE JOURNAL of the American Medical Association and of the state medical society journals that they call attention to the members of the Association that they are not only cordially invited but urged to attend the sessions of the House of Delegates and to attend and participate in the hearings of the reference committees. It is further urged that the editors of state journals and of county medical society bulletins be encouraged to attend sessions of the House and of reference committees in order to obtain at first hand information of paramount importance and thus to disseminate it more rapidly to the profession at the local level.

Messages to Drs. Stephen E. Gavin and James Stevenson

It was announced that Dr. Stephen E. Gavin, Wisconsin, and Dr. James Stevenson, Oklahoma, each of whom has served in the House of Delegates for many years, had been ill and had sent their regrets for their inability to attend the Miami meeting. The House of Delegates voted unanimously to send messages of regret for their absence and best wishes for early recovery to Drs. Gavin and Stevenson.

Address of the President, Dr. Walter B. Martin

Dr. Walter B. Martin, President, delivered his address, which was referred to the Reference Committee on Reports of Officers. (See Dr. Martin's address in THE JOURNAL, Dec. 18, 1954, pages 1504-1505.)

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

Dr. Warren W. Furey, Chairman, submitted the following report, which was adopted:

Address of the President, Dr. Walter B. Martin: Your reference committee has carefully reviewed the presentation made by the President, Dr. Martin, and would like to commend him most highly for the position he has maintained not only in this address but in all other appearances he has made as the spokesman for American medicine. He has conducted himself in a manner that should make us proud of the high caliber of men we have selected as officers to represent us before the American public. He is indeed well fitted to follow in the footsteps of his distinguished predecessors. His address leaves little room for reference committee comment. Your committee feels, however, that it would be remiss in its duty if it did not stress a few of the more pertinent points raised, including: 1. The important work being done by the Committee on Legislation and the Washington Office was emphasized particularly to indicate that organized medicine at all levels should be primarily concerned as to the effect of the proposed legislation for good or evil on the medical welfare of the people. 2. It was very properly stressed that "of first importance is the continuing effort to meet the medical needs of the low economy and other noninsurable groups. We have committed ourselves to the policy that the medical care of this group is the responsibility of the states and localities with determination of both economic and medical needs at the local level." 3. In commenting on the voluntary methods of prepaying the cost of health care, it was stated that it is our responsibility to supply the medical care and to assure that the quality of the care is satisfactory and that its usage is not abused. 4. In the matter of hospital-physician relations, the President has presented a reasonable position which should be seriously considered by all concerned. This matter has already been acted on by the House today (Dec. 1, 1954). Therefore, your committee has no specific recommendation to make regarding it. Your committee would like to call to your attention the following statement: "It must be recognized, however, that the practice of medicine is a profession and not a corporate prerogative." Wider acceptance of this statement could go a long way toward a better understanding of this problem, if not affording a complete solution of it. 5. In further remarks, attention was called to the constructive work being done by the American Medical Education Foundation, the Woman's Auxiliary, the World Medical Association, and other activities of medical interest.

It is the feeling of your reference committee that individual members of the Association should avail themselves of the opportunity to read and carefully study this address and that they should be guided by it in their relations with one another and with the public. In this way, to use Dr. Martin's words, "The medical welfare of our people can best be served by strong local societies laboring diligently for the total good of their own people. These societies, firmly bound to their state societies and to their Association, can become a strong and moving force for the health of the nation."

Introduction and Remarks of Student A. M. A. Delegates

The Speaker introduced Mr. John A. Oates Jr., Bowman Gray School of Medicine, and Mr. Nelson M. Fox Jr., Medical College of Virginia, delegates from the Student American Medical Association. Mr. Fox presented greetings, and Mr. Oates addressed the House as follows:

Mr. Speaker and My Future Colleagues: It is a pleasure for me to bring to you the report this morning that our Student A. M. A. at the end of its fourth year of existence is continuing not only to progress but also to reach many of the goals for which it has set out. Our membership has increased until at present we include over two-thirds of all of the medical students throughout the country. Our activities have so expanded that, to take care of our enlarged activities, it has been necessary for us to move into a new suite of offices, which are just down the street from your national headquarters at present. It will also be of note for you to know that through our new insurance program that we have set up and through increased financial revenue from other sources, our Student A. M. A., as of Jan. 1, 1955, is planning to assume complete financial responsibility for its budget and to be completely self-supporting. I am sure that the fathers who support most of the medical students in the country today must be extremely envious of the American Medical Association in having an offspring that, at the age of four, is assuming its own financial responsibilities. I believe that the American Medical Association should be justly proud of this fact, for it is because of your mature advice and friendly help that we have been able so early to achieve this position. This has been possible through the help that we have received from the American Medical Association, and because many of the state and county medical societies have enabled our men to see organized medicine in action, and many of them have provided the impetus that has given success to a number of our local societies in the schools throughout the country. For this we are very grateful because, as is the case in your organization, it is also true in ours, our local societies are the backbone that provides us with everything we can do.

It is our hope, gentlemen, and also our belief, that in our position now as an autonomous organization, with your continuing cooperation, we may strive to the end that our Student A. M. A. members may graduate immediately into the practice of medicine with a concrete sense of responsibility toward organized medicine and toward their communities. I thank you.

Presentation and Address of President of Woman's Auxiliary

Mrs. George Turner, President of the Woman's Auxiliary, was presented to the House by the Speaker, and delivered the following address:

Mr. Speaker, Dr. Martin, Dr. Hess, Board of Trustees, and Members of the House of Delegates: I appreciate the privilege of reporting this half year of Auxiliary progress to you and bringing greetings from our 67,000 members. The framework of our organization is complete, but we are not content. There are 797 county medical societies that do not, at the present time, enjoy the partnership of an auxiliary. In conformity to policy laid down by the Auxiliary advisory councils from the American Medical Association, the state medical associations, and the county medical societies, we must contact the president of each of these societies and through him gain permission to contact the wives for organization purposes. Each of these societies will be approached this year. Organization is a point of emphasis in the Auxiliary. We need the helping hands of new members and the financial support of their dues. Our goal is a 10% increase each year in membership. We need your help to attain it. Our present membership is carrying the load of the whole program, which is to educate ourselves on subjects related to medicine and to deliver the message to the people of our communities through participation in the programs of other organizations to which we belong.

We think our program theme, "Leadership in Community Health," is an appropriate one. People in the local communities are coming to depend on us for guidance in their health programs and to accept the information we give them with confidence. We are aware that we are looked upon as a reflection of the profession in all we say and do. Therefore, we study to be carefully informed before expressing an opinion on the problems of health and medical care.

OUR PROGRAM

Last year, the combined auxiliaries contributed approximately $52,000 to the American Medical Education Foundation. We aim to double that amount this year. We contribute $100 annually to the World Medical Association and the careers committee of the National Nursing League. Since the inception of our nurse recruitment program in 1945, we have raised $250,000 for nursing education. Our future nurses clubs interest high school students in choosing nursing as a career.

We are interested in distributing *Today's Health* magazine because we know its educational and public relations value. We added 40,000 subscriptions to the list last year. This year, through "Operation Christmas" and "Operation M.D. and

D.D.S.," we expect to place it in many more homes and the reception rooms of all physicians and dentists. Here, again, we need your cooperation.

The other aspects of our program are more difficult to evaluate. We study medical legislation; we cooperate in the civil defense program; we are developing a mental health program under your guidance; we assist in rural health programs, health days, health fairs, health forums, and health councils; and we devote programs to the study of the history and functions of the American Medical Association, the World Medical Association, and the World Health Organization. As individuals, we assist in community health and philanthropic projects and drives, such as polio, cancer, tuberculosis, and heart drives, and the Crusade for Freedom. With our personal physician's help and approval, we will choose "A Family Doctor for Every Doctor's Family" as an example of good health practice. To fill community needs, we are emphasizing programs on safety in traffic, homes, and schools. Your Auxiliary recently became a member of the National Safety Council. GEMS (Good Emergency Mother Substitutes) is the name of our baby sitters' safety training course for high school girls. This is a new project, but it has received favorable comment in the press and on television.

Our annual conference of state presidents, presidents-elect, and national committee chairmen, which was held in Chicago 10 days ago, was well attended by all states. We thank you for the assistance of the department representatives from the American Medical Association and for Dr. Martin's recorded address. The information gained here furnishes inspiration and information for those attending to use it at home in developing their own state and county programs.

I have attended eight state auxiliary conventions, three state auxiliary board meetings, the Southern Medical Association Auxiliary Convention, and six national organization meetings. The most recent one was the American Heritage Foundation's Crusade for Freedom, which took the leaders of 72 organizations on a 10 day, 12,626 mile pilgrimage to inspect the broadcasting facilities and effectiveness of Radio Free Europe.

Introduction and Address of Mr. Seaborn Collins, National Commander, American Legion

The Speaker introduced the national commander of the American Legion, Mr. Seaborn Collins, who addressed the House. (See THE JOURNAL, Dec. 18, 1954, pages 1510-1511.)

Presentation of Distinguished Guests

The following distinguished guests were introduced by Dr. Elmer Hess, President-Elect, and the Speaker, respectively, and presented greetings or a brief address, which will be included in the official proceedings of the House of Delegates:

Dr. Howard Snyder, personal physician to the President of the United States.

Dr. Kenneth Babcock, Director, Joint Commission on Accreditation of Hospitals.

Report of the Secretary

Dr. George F. Lull, Secretary, presented his report (see THE JOURNAL, Oct. 30, 1954, pages 866-868), which was referred to the Reference Committee on Reports of Board of Trustees and Secretary.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF BOARD OF TRUSTEES AND SECRETARY

Dr. Eugene F. Hoffman, Chairman, presented the following report, which was adopted:

Membership: Your committee is grateful to see that the membership income for the first eight months of 1954 has shown an increase of more than $97,000, for a total of $3,020,975.50 over the comparable period of 1953. The total paid membership of 121,064 reported by the Secretary shows a net increase of 4,001. Your committee also noted that many component and constituent associations have changed their constitutions so that there is a uniformity in membership regulations. It urges those who have not done so to contact the Secretary so that he may assist them in any constitutional changes that are necessary.

The Secretary calls attention to the fact that there are 7,000 new medical students graduating each year and 25,000 physicians serving internships, residencies, and fellowships in approved hospitals, many of whom are not associated with organized medicine. Your committee recommends that the component societies and constituent associations offer these physicians a type of membership with no membership fee or a nominal fee so that they can become eligible for membership in the American Medical Association.

The Board of Trustees has implemented the resolution dealing with the reserve officers in the U. S. Public Health Service on active duty. These officers are now eligible for exemption from the payment of dues provided they are active members of their constituent associations.

Your committee is pleased to note that the Secretary has been able to shorten the time intervals between the payment of dues and the delivery of THE JOURNAL or of the specialty journals to the members.

Directives of the House of Delegates: The Secretary has made disposition of resolutions and recommendations adopted by the House of Delegates at the San Francisco meeting, which are not specifically directed to the Board of Trustees or stated councils or committees.

He has received and reported the amended Executive Order 10450 of April 27, 1953, relating to security requirements for government employees.

The reply of the chief medical director of the Veterans Administration concerning Resolution No. 60 to the effect that the Veterans Administration has no choice but to observe the law regarding the establishment of service-connected disabilities reemphasizes the necessity of continuing close liaison of the various committees of the American Medical Association and the committee on veterans affairs of the House of Representatives, the committee on finance of the United States Senate, and the American Legion, in an attempt to seek adoption of the policy of the House of Delegates on these matters.

Staff Policy Committee: On Sept. 3, 1954, the Secretary again demonstrated his executive ability by appointing a Staff Policy Committee. This committee will act as a coordinating and planning committee to consider the problems, programs, and plans of the various councils, bureaus, and departments of the Association with a view to increased efficiency, greater understanding, and over-all participation in the functions of the Association.

Activity in the Field: The Secretary and Assistant Secretary have attended and participated in many meetings of county and state societies, auxiliaries, and other organizations with which the Association maintains cordial and cooperative relationships. They have also attended the meetings of the Board of Trustees and Executive Committee as well as many meetings of the Association's own councils and committees.

In conclusion, your reference committee wishes to express publicly its grateful appreciation and thanks, as well as the grateful appreciation and thanks of the House of Delegates, to the Secretary and Assistant Secretary and to all the personnel of the Association for their loyalty and faithful service.

Report of the Board of Trustees

Dr. Dwight H. Murray, Chairman, presented the report of the Board of Trustees (see THE JOURNAL, Oct. 30, 1954, pages 868-892, and Nov. 6, 1954, pages 959-975), which was referred to the Reference Committee on Reports of Board of Trustees and Secretary with the following exceptions:

To the Reference Committee on Legislation and Public Relations: Report of Department of Public Relations; Report of Washington Office; Report of Committee on Legislation.

To the Reference Committee on Medical Education and Hospitals: Deductibility of Postgraduate Medical Expenses.

To the Reference Committee on Hygiene, Public Health, and Industrial Health: A. B. A. Committee on Narcotics and Alcohol; Report of Committee on Mental Health; Report of Council on Industrial Health; Report of Bureau of Health Education; Committee on Pesticides; Report of Council on Physical Medicine and Rehabilitation; Report of Council on Foods and Nutrition.

To the Reference Committee on Medical Military Affairs: Report of Council on National Defense.

To the Reference Committee on Insurance and Medical Service: Report of Council on Rural Health.

To the Reference Committee on Sections and Section Work: Report of Council on Scientific Assembly; Report of Bureau of Exhibits.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF BOARD OF TRUSTEES AND SECRETARY

Dr. Eugene F. Hoffman, Chairman, presented the following report, which was adopted:

REPORT OF THE BOARD OF TRUSTEES

Your reference committee, along with the House of Delegates, wishes to congratulate the Student American Medical Association. As of Oct. 1, 1954, they have "come of age." We wish them continued success in their endeavors.

Your committee believes that the Board of Trustees acted wisely in creating a Law Department with Mr. C. Joseph Stetler as its director and Mr. J. W. Holloway Jr. as consultant to the department.

THE JOURNAL continues to improve through the use of new techniques and knowledge gained from the two surveys in 1950 and 1953. Innovations in the use of cartoons, pictures, histories of state associations, increase of medical abstracts, and increase of the number of pages of scientific reports and medical news, to mention a few, have continued to make THE JOURNAL the acknowledged world leader in its field. THE JOURNAL is now mailed, through subscriptions, to 119 countries. The Editor, through the adoption of more efficient organization and administration, has been able to reduce the cost and gain greater efficiency in the department of specialty journals. The policy of new cover design, improved format, more color in illustrations, new features, and expanded coverage of specialty articles will make these journals more readable and instructive to their subscribers. Improved techniques in administration have permitted the journals to be published during the month due. The net decrease of 433 in subscriptions has been due to the cancellation of subscriptions carried without instructions from the subscriber. However, the circulation of THE JOURNAL and the nine specialty journals has remained about the same. It is hoped that a drive can be made next year to obtain an increased circulation of these journals.

Your committee is highly complimentary concerning the activities of *Today's Health*. The editorial policy adopted four years ago has demonstrated an increased salability of the magazine. The continued interest of the House of Delegates along with the combined efforts of many others has made *Today's Health* a leader in the field. This is amply demonstrated by the continued and increasing demand for permission by other magazines to reprint with credit articles from this periodical.

Your committee would be remiss in its duty if it neglected to recognize the magnificent contribution of the Woman's Auxiliary to the American Medical Association in promoting *Today's Health* and increasing its circulation. The net paid circulation of 328,858 for the month of September, 1954, is a tribute to the combined efforts of many. It is the opinion of the editor that *Today's Health* can eventually reach a circulation of one million. To accomplish this, certain recommendations have been made. The Board of Trustees has authorized: (1) the reorganization of *Today's Health* as a complete functioning unit; (2) the appointment of an executive publishing editor, Mr. William Hetherington; (3) the formation of an editorial board consisting of Dr. W. W. Bauer, chairman, and Drs. Walter E. Vest, Julian P. Price, Austin Smith, George F. Lull, and Mr. Leo Brown. It is hoped that this new policy will accomplish all of the aims and ambitions of *Today's Health*. Your committee is pleased to see that Dr. W. W. Bauer will continue to devote his talents to the magazine.

The library continues to be the center of reference activity with more than 11,000 periodicals loaned. Your committee is proud of its activities, particularly its philanthropic work of aiding other libraries less fortunate by the donation of many journals.

Volume 45 (Jan. to June, 1949) of the Quarterly Cumulative Index Medicus was published this year. Volume 52 (July to December, 1952) was mailed to subscribers in August, 1954. Volume 53 is now in the process of editing.

Your committee acknowledges the efforts of the editor and his associate editors in the preparation of the fifth edition of Standard Nomenclature of Diseases and Operations. Only those familiar with this volume can appreciate the tremendous effort expended in its preparation. The continuing increase in the use of the nomenclature by hospitals (75% at present) will eventually standardize the statistical material available from these institutions.

The State Journal Advertising Bureau continues to assist the present membership of 33 state journals, the official publications of 37 state medical associations. The Bureau secures advertising space sales and handles all details for the convenience of the state journal offices. The net sales for the first nine months of this fiscal year amount to $525,739.25, an increase of 29.92%.

Your committee anticipates with pleasure the publication in mid-1955 of the new edition of the American Medical Directory. It realizes the difficulties that ensued when this House of Delegates saw fit to reorganize the classification of membership. The change in membership structure required new office procedures and techniques in many state association offices as well as in the American Medical Association. These changes delayed the completion of accurate membership lists. The new symbols to be used in the Directory for membership designation are clear and concise and will clarify a situation that has been confusing to many members at large.

Subcommittee on Medical Malpractice Problems: Your committee approves of the action of this subcommittee in its collaboration with 56 medical schools by the free distribution of copies of "Malpractice and the Physician," and is also pleased to see that the exhibit on malpractice will continue to be shown. Your committee would suggest to the Board of Trustees that it consider a change in name of this Subcommittee on Medical Malpractice to Subcommittee on Professional Liability.

Report of Subcommittee on Courses in Medical Jurisprudence: Your committee concurs with the subcommittee that a handbook on legal medicine would be a valuable aid in the instruction of the medical student and recommends that the subcommittee continue to assist in its publication. It cannot be too strongly recommended that both of these subcommittees continue their activities in the field of medical education.

Subcommittee on Chemical Tests for Intoxication: Your committee congratulates this subcommittee for the preparation and display of the fine exhibit of chemical tests to determine intoxication. This activity, along with the publication of a manual on tests for intoxication, again demonstrates that the American Medical Association must continue in the field of education. It, along with other organizations, must continue to protect the public from the intoxicated driver.

Your committee will await the future reports from the subcommittees on Forensic Psychiatry and Forensic Pathology on the development of programs in their fields and likewise looks forward to the supplementary report from the Subcommittee on the Medicolegal Status of Blood Tests in Disputed Paternity Cases.

Your committee believes that the Committee on Medicolegal Problems should continue to sponsor sessions on legal medicine similar to the meeting held in San Francisco and further believes that the committee should continue its activities in the promotion and adoption of a Model Postmortem Examinations Act. Your committee requests that all state medical associations ask for aid from this committee when it can be of service to them in the modernization of a coroner system.

Report of the Bureau of Legal Medicine and Legislation: This is the final report of the Bureau of Legal Medicine and Legislation. As of Aug. 1, 1954, the function of this Bureau along with the legal duties performed by other departments of the American Medical Association were transferred to the Law Department.

Your committee is grateful that the nuisance of the one dollar certified check for the payment of the Harrison Narcotic Act Tax has been eliminated through the efforts of this Bureau and trusts that the appropriate regulation will soon be issued.

Volume 5 of the abstracts of medicolegal decisions was issued during the fall of 1954. It will continue to act as a reference source along with the previously published volumes.

Your committee concurs with the Bureau that the end does not justify the means used in the entrapment of pharmacists and hopes that a cooperative basis can be reached between the federal agencies and the medical and pharmaceutical professions in the joint enforcement of the laws dealing with prescription of drugs.

Your committee trusts that the Law Department will fully explore and report to the House of Delegates the question of conditional imposition of a sentence dealing with infraction of the Harrison Narcotic Act in regard to the right to register under that act. It also requests that the invasion of states' rights by the federal government concerning the surrender of a state license to practice medicine be further explored. Your committee further requests that the Law Department consider the matter of the importation of narcotics by physicians.

American Medical Association
Statement of Expense Comparison
Councils, Bureaus, Committees and Selected Departments
Years 1950-1955

	1950	1951	1952	1953	1954 Partly Estimated	1955 Budgeted
Association Activities	$ 101,007	$ 140,086	$ 159,904	$ 249,868	$ 306,063	$ 230,701
Secretary's Office	96,559	83,538	81,336	88,618	88,465	99,946
Office of Secretary to Board of Trustees	.....	.....	9,786	10,276	13,648	16,165
Student A. M. A.	.....	12,905	23,289	25,992	23,584	.....
American Medical Education Foundation						
Contributions	500,000	500,000	500,000	500,000	.....	.....
Department Expense	.....	14,641	44,160	71,856	90,443	100,000
Public Relations Department	102,116	209,212	285,048	385,461	308,250	325,045
Washington Office	158,160	180,483	175,643	185,743	206,064	220,982
Council on Medical Education and Hospitals	177,767	212,018	292,489	354,679	372,950	395,682
Survey of Medical Education	58,239	64,054	51,652	599†	.....	.....
Council on Medical Service	89,328	100,338	111,239	137,275	167,200	195,650
Council on Pharmacy and Chemistry	135,469	118,290	127,775	143,394	161,230	167,470
Council on Physical Medicine	49,070	56,946	74,791	79,047	92,906	94,600
Council on Foods and Nutrition	36,035	41,336	48,154	54,616	63,921	67,940
Committee on Cosmetics	13,351	15,301	16,106	17,744	20,660	22,625
Committee on Research	33,707*	39,556	48,240	51,072	74,368	77,040
Chemical Laboratory	72,150	68,913	70,461	73,795	80,837	93,564
Microbiologic Laboratory	.....	11,957†	18,587	19,591	22,353	21,091
Council on Industrial Health	64,626	67,887	72,010	57,453	75,500	87,500
Council on National Defense (National Emergency Medical Service)	36,721	39,851	36,493	45,533	42,651	39,910
Council on Rural Health	34,642	31,546	43,588	52,529	63,915	70,075
A. M. A. Library	48,715	54,840	61,734	71,085	73,190	76,075
Bureau of Exhibits	38,181	65,320	84,593	102,157	99,079	102,875
Bureau of Health Education	150,578	208,788	221,837	267,021	260,286	270,971
Bureau of Investigation	20,149	21,214	26,087	28,496	31,783	42,290
Bureau of Legal Medicine and Legislation	52,722	51,484	57,756	65,513	39,099†	.....
Law Department	.....	.....	.....	.....	38,000†	101,645
Judicial Council	4,369	4,122	4,373	4,230	5,765	13,900
Committee on Medico-Legal Problems	139	3,023	3,757	2,931	4,850	8,200
Committee on Legislation	4,822	4,080	4,566	12,973	21,532	21,060
Council on Constitution and Bylaws	.....	1,923	2,219	3,238	2,175	3,680
Bureau of Medical Economics	140,312	180,329	169,182	184,555	183,184	228,500
Committee on Mental Health	.....	.....	9,321†	30,903	37,734	53,179
Membership Records, and Membership Conversion in 1951-1952-1953	47,270	64,293	227,297	273,788	289,716	227,603
Biographical Records	72,177	80,576	105,881	99,208	165,459	172,493
Meetings—Annual	30,562	(10,872)‡	20,869	22,803	39,551	234,691§
Meetings—Clinical	41,267	90,610	64,507	55,164	79,000	134,109§
TOTALS	$2,410,210	$2,823,618	$3,354,780	$3,829,296	$3,645,471	$4,017,257

* Includes Committees on Therapeutic Trials $12,496 and Therapeutic Research $7,998.
† Less than full year.
‡ Gain. § Excludes anticipated income.

The right of a hospital to use tax-free alcohol in its laboratory has been defined. Your committee wishes to acknowledge the aid given by the Bureau in the planning stages of the publication of Medical Trial Technique Quarterly. The Bureau is to be complimented on the drafting of a code of interprofessional (medical and legal) ethics. Your committee concurs and wishes to reemphasize the importance of a better understanding on the part of both the physician and the attorney in the many areas in which medicine and law interweave.

Your committee recommends that this House, with the consent of the Speaker, show its appreciation by a rising vote of thanks to Mr. J. W. Holloway Jr. and the personnel of the former Bureau of Legal Medicine and Legislation for their splendid work and untiring cooperation with the Association.

Report of the Bureau of Medical Economic Research: Your committee is deeply grateful for the work performed by the Bureau of Medical Economic Research under Dr. Frank G. Dickinson. Owing to the importance of bulletin 94, entitled "Distribution of Physicians by Medical Service Areas," we shall quote a portion of this report:

> 1. Although 1/6 of the land area of the United States was beyond a 25 mile radius from any physician in active private practice, only 1/6 of 1% of the population of the United States resided there. 2. Every city, town, or village with a population of more than 5,000 had at least one physician in active private practice, as did 96% of the places with a population of from 2,500 to 5,000 and 88% of the places of from 1,000 to 2,500 population. In fact 3/5 of the places with a population between 750 and 1,000 had an active physician, and a total of 15,192 places with more than 100 persons had at least one physician, compared with 12,200 such places with an independent retail drugstore, 9,100 with a dentist, and 3,600 with a registered hospital. 3. The population per physician did not vary as much from area to area as other characteristics of the 757 areas. 4. Only 361 additional physicians would have been required in the 75 areas that had more than 2,000 persons per physician to have reduced the ratios in every one of these 75 areas to less than 2,000 persons per physician. This small number, 361, which some might consider a "national shortage" of physicians, is in sharp contrast to the estimates of shortages ranging from 22,000 to 49,000 emanating from Washington in recent years. Moreover, only 2,530 additional physicians would have been required in the 262 areas with more than 1,500 persons per physician to have reduced the ratios in every one of these 262 areas to less than 1,500. 5. This long study clearly demonstrates that the distribution of physicians in the United States in April, 1950, in relation to the persons whom they served was excellent but not perfect.

In view of the length of this report it is not practical to quote in detail the activities of the Director of the Bureau as reported under the heading of Pensions. However, your committee would be remiss in its duty if it did not emphasize the importance of these activities. It therefore recommends that you reread this section of the Bureau report. Your committee commends the Bureau for its activities in behalf of the individual voluntary retirement system of the Jenkins (Reed)-Keogh type.

Your committee is proud of the expansion and the increasing usefulness of the IBM section of this bureau. Only those with a knowledge of the perforations in the punch cards can appreciate the flexibility and the efficiency of the IBM section. Your committee trusts that the section will continue its cooperation with the various councils, committees, departments, and bureaus of the American Medical Association.

Report of Council on Pharmacy and Chemistry: Your committee is appreciative of the fact that the medical profession can continue to depend on this council for its advice regarding the acceptance of drugs for use in the field of therapy. It also acknowledges the continuing cooperation of the pharmaceutical manufacturers in the submission of worth-while drugs for evaluation. Two new books, the "Fundamentals of Anesthesiology," and "Glandular Physiology and Therapy," have been published. New and Nonofficial Remedies was distributed in June, 1954. The Epitome of the U. S. P. and N. F. will appear as soon as possible next year.

Your committee commends the Committee on Research in the field of cooperative investigations. The Committee on Grants-in-Aid, through its research, continues to demonstrate the philanthropic aims of organized medicine.

Report of the American Medical Association Laboratories: Your committee wishes to recognize the work performed by the laboratory in the many tests, analyses, and evaluations of drugs presented to the Council on Pharmacy and Chemistry

and the cosmetics presented to the Committee on Cosmetics. It anticipates the publication of the full report on cigarets, cigaret smoke, and filters and continues to look to the Microbiologic Laboratory for its continuing protection and maintenance of standards.

Report of the Committee on Cosmetics: The Committee on Cosmetics continues to promote a better understanding of cosmetics between the profession and the public. The cooperation of the committee with the various public agencies again demonstrates the Association's interest in the general welfare of the public.

Report of the Bureau of Investigation: The Bureau keeps us advised of the advances in the field of "unscientific medicine." By these exposures the Association continues to educate the uninformed.

Statement of Expense Comparison: Your committee notes the continuing rise in the cost of operation, shown in the accompanying table (see page 1596), due to the many economic factors over which it appears that we have no control.

Your committee wishes to call your attention to the splendid work performed by the Board of Trustees. It believes that we all owe them our deep gratitude, appreciation, and sincere thanks.

REPORT OF REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS

Dr. William L. Estes Jr., Chairman, submitted the following report, which was adopted:

To your committee was referred the report of the Department of Public Relations, the report of the Washington Office, and the report of the Committee on Legislation.

The deliberations of your committee resulted in a most interesting conference on the problems of public relations and legislative matters that concern the American Medical Association. The committee is particularly grateful to those who attended its meeting, especially to Mr. Leo Brown, Director of the Department of Public Relations, and Dr. David B. Allman, Chairman of the Committee on Legislation, as the discussion of the reports submitted by these men and the Washington Office provoked a most enlightening and profitable round table exchange of ideas. As a result, the following report is submitted:

Public Relations Department: The report of the Department of Public Relations is a comprehensive summary of the tremendous volume of services rendered by the well-organized group presided over by Mr. Leo Brown. The department has continued to stress the American Medical Association's positive, constructive activities with the general objectives of increasing public understanding of medical problems and policies, improving physician-patient relationships, promoting closer and more effective relations between the Association and its members, providing practical assistance to state and county medical societies for the development of positive public relations programs, and spreading knowledge of all sound methods of solving the socioeconomic problems involved in modern medicine.

The report delineates its activities, carried out with the advice and suggestions of its advisory committee, as consisting of:

1. Press relations
2. Magazine relations
3. Television and film program
4. Literature and pamphlet distribution
5. Services to state and county societies
6. Services to councils, bureaus, and committees
7. Services to President and President-Elect
8. Special articles
9. Public relations meetings
10. Presidential inauguration ceremony
11. General and miscellaneous services, which include organizing the guided tour of the Association's headquarters program, and field services to county, state, and other national organizations, particularly to the General Federation of Women's Clubs

The Association, through its Public Relations Department, is continually extending the scope of its contacts with the public. Every medium of communication is being utilized to achieve its objectives. Even though critical articles or comments in magazines and newspapers occasionally receive more than their proportionate share of attention, they are far outnumbered by the increasing volume of favorable, constructive information reaching the public eye and ear. Your committee has noted with special approbation that the public relations group carefully checks derogatory articles concerning the medical profession appearing in periodicals of all types to ascertain those that merit an answer or those whose authors should be advised of factual material of which they are apparently unaware. The Public Relations Department is planning to continue this broad plan of procedure. Efforts will be continued to achieve the Association's public relations objectives, and in the coming months particular emphasis will be placed on familiarizing the general public with the reasons for organized medicine's policy on controversial legislation and other issues. Leo Brown and his indefatigable assistants cannot be commended too highly for a marvelous and effective program covering most efficiently so broad a spectrum of public relations for the American Medical Association and its constituent societies.

Washington Office: The report of the Washington Office stresses its heavy responsibilities in view of the Administration's ambitious health program. Its activities consisted, particularly, in direct daily contact with Congress in an effort to promote sound medical legislation and to prevent the passage of bills that would be detrimental to good medical care. These efforts were directed by the Board of Trustees and supported by the Committee on Legislation, state medical societies, and thousands of individual physicians. It is to be noted that 1954 marked the 10th anniversary of the Washington Office. At its founding it consisted only of a Director; now it includes, besides the Director, a physician assigned to the Senate and one to the House, a legal staff, an editorial staff, and a publication staff—in all, 18 persons.

One hundred thirty-three bills introduced in Congress considered of interest to the medical profession were studied, analyzed, and reported in the weekly A. M. A. Washington Letter. Congressmen and committee staff personnel were supplied with information on legislative proposals of interest to the American Medical Association, particularly concerning health reinsurance, the Mortgage Loan Bill, and social security changes. An 18 page report on these efforts was distributed to the appropriate officers, committee members, and members of the House of Delegates. The director and his assistants spoke at various medical meetings throughout the country to depict the activities of the American Medical Association's legislative office and attended many conferences with representatives of other organizations.

A new publication, "The Month in Washington," was issued this year, which summarizes Washington news for use in state and regional journals. Twenty-nine journals receive this document. News releases to inform the press and radio of American Medical Association views are also prepared. The mailing list of the Washington Letter, however, is now 6,781 and includes high-ranking government officials. While there has been an effort to restrict this mailing list to those particularly interested in legislative matters, it is the opinion of your committee that the mailing list should include the chairman of each state legislative committee and the president and secretary of each county medical society. Twelve special reports have also been issued during the year, notably that concerning the study of the medical and health budget of federal agencies. More office floor space was rented to cope with all this greater editorial activity. A summary of the important medical legislation enacted by the 83rd Congress concludes the report.

This brief review indicates the far-reaching efforts and the progressively expanding sphere of influence of our Washington Office. That its reports and endeavors are of interest to an ever-increasing clientele, both in and out of the profession, is a matter of gratification. Dr. Frank Wilson, Director, and his associates are to be commended for a peculiarly efficient service so splendidly rendered.

Committee on Legislation: The Committee on Legislation reports that out of 407 measures reviewed 65 major legislative proposals have been analyzed this past year, and policy positions on these have been recommended to the Board of Trustees. A year ago, Dr. David B. Allman, New Jersey, was elected

Chairman to succeed Dr. F. J. L. Blasingame, Texas. Drs. Harlan English, Reuben B. Chrisman Jr., and John E. McDonald are other new members of the committee.

A résumé of measures dealt with, action taken, and nature of testimony on which either oral or written statements were presented is outlined. Six regional legislative conferences to explain and perfect the system used by the committee in alerting key legislative personnel were held in the first two months of 1954. The success of these has been so outstanding that the Board of Trustees has authorized the committee to conduct similar conferences every other year. Your committee feels that these conferences have served a splendid purpose and that the House of Delegates should note with infinite satisfaction the authorization of the Board of Trustees to continue them at stated intervals. The accomplishments of the fine liaison and effective cooperative effort of the Washington Office and the Committee on Legislation have been so outstanding that your committee recommends to the House of Delegates that approbation and acclaim in appropriate superlatives be offered to these faithful guardians over the legislative health of the American people.

In conclusion, your committee would offer the following specific recommendations to the House:

1. That there be a reexamination of the objectives of the Public Relations Conference immediately preceding the interim meeting of the Association in order to broaden the base of its program and thereby increase its effectiveness;

2. That in order to furnish further advisory sources for the Committee on Legislation, some mechanism be developed to obtain the attitude of each state medical society on pending federal legislation;

3. That the House of Delegates approve the carefully planned expansion program of the Public Relations Department, which is taking place from year to year, within budgetary limits, commend this scientific approach to adequate coverage of the Association in this field, and recommend its continuance at as rapid a pace as conditions justify.

REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Dr. Walter P. Anderton, Chairman, presented the following report, which was adopted:

Your reference committee had referred to it that portion of the report of the Board of Trustees dealing with the subdivision of its report coming from the Bureau of Legal Medicine and Legislation and specifically concerned with deductibility of postgraduate medical expenses. Your committee noted with approval that progress was being made toward the obtaining of a ruling from the United States Commissioner of Internal Revenue to provide appropriate information concerning deductibility of postgraduate medical expenses.

REPORT OF REFERENCE COMMITTEE ON HYGIENE, PUBLIC HEALTH, AND INDUSTRIAL HEALTH

Dr. Warde B. Allan, Chairman, submitted the following report, which was adopted:

In the report of the Board of Trustees, your committee notes that the Bureau of Legal Medicine and Legislation is continuing its cooperative work with the American Bar Association Committee on Narcotics and Alcohol for at least another year. This is a very worth-while project and of national importance to all groups concerned. It is understood that this is continuing under the direction of the Law Department.

Report of the Committee on Mental Health: This Committee has had a full year. It appears that its work will be increasing. The Board of Trustees has added one new member to the Committee, as requested by the Section on Nervous and Mental Diseases. The Committee on Mental Health has covered many facets related to its field. Its statement concerning licensure or certification of clinical psychologists, worked out in conjunction with the American Psychiatric Association and the American Psychoanalytic Association, is, your reference committee feels, very comprehensive and fair.

The Committee on Mental Health took an active part in the Washington Conference on Mental Health, where all interested national groups, both private and governmental, took part in discussions referrable to training of mental health workers, treatment, prevention, and research. Considerable progress was made, and the same group plans to meet again in October, 1955. A pilot research project on the effects of crime portrayal in mass media on children and adolescents is under way. This is of vital importance to all of us. Your reference committee feels that the work of this group should be continued. The report of the Subcommittee on Alcoholism is a very detailed and comprehensive one. It outlined a program for discussion at the meeting of the mental health representatives of the state medical associations in September, 1954.

The Committee on Mental Health is to be commended for the caliber and scope of its work in the past year, and your reference committee recommends to the Board of Trustees that it consider giving council status to this committee.

Report of the Council on Industrial Health: This report has been reviewed in detail. The Council is to be congratulated on the work it has done over the past year. It is broadening its field of endeavor and cooperating with various lay and professional groups to improve the medical care for industrial workers. Its work in the field of workmen's compensation has been outstanding, and your reference committee urges that it be continued at its present high level. We note with regret the severe loss to this Council in the death of Dr. James Stevens Simmons.

Report of Bureau of Health Education: This is a very complete report of the work of this Bureau covering its various fields of endeavor, namely:

(1) Questions and answers from lay correspondents in this country and abroad: These questions covered a broad spectrum of medical problems, and there were 13,863 such requests in the year ending Aug. 31, 1954.

(2) Loan and collection of lay medical articles.

(3) Television and radio dissemination of medical knowledge: This is becoming an ever-increasing field of endeavor. Your reference committee commends the handling of the radio and television services in connection with the St. Louis Clinical Meeting and the San Francisco Annual Meeting.

(4) Health and Fitness Division: Two consultants staff this division, and it is an integral part of the Bureau of Health Education. It deals with school health policies and programs.

The Bureau of Health Education cooperates with many groups, such as the American Public Health Association, the National Society for the Prevention of Blindness, the National Safety Council, and United States governmental agencies. It is to be hoped that the work of this Bureau will continue at its present high level of effectiveness. Your reference committee requests the Bureau of Health Education to explore further the possibility of publishing informative articles by capable medical authors and authorities in lay magazines. By this means the great mass of the people could be reached and the biased opinions of lay authors of medical matters could be refuted. This, your committee feels, would not detract from the effectiveness of *Today's Health*.

Report of Committee on Pesticides: This report is indicative of the excellent work of this Committee. Your reference committee hopes that it will be continued.

Report of the Council on Physical Medicine and Rehabilitation: This Council has been very active in the past year and, as will be seen in its report, has kept a vigilant eye on various devices and, in your committee's opinion, has been extremely judicious in its decisions regarding said devices.

Report of Council on Foods and Nutrition: This again reveals the broad scope and vigorous activities of this group. This is an informative report and is called to the attention of the House of Delegates and members of the American Medical Association.

REPORT OF REFERENCE COMMITTEE ON MEDICAL MILITARY AFFAIRS

Dr. Bruce Underwood, Chairman, presented the following report, which was adopted:

Your reference committee met and considered all the matters that were referred to it. It appreciated the assistance, information, and advice that was given it by the representatives of the Board

of Trustees and its Council on National Defense, representatives of the Department of Defense and its branches, representatives of the National Medical Veterans Society, and the various persons who appeared before your committee. Your reference committee's report is divided into four major sections according to subject matters.

"Doctor-Draft" Law: This section of your reference committee's report deals with the report of the Board of Trustees and its Council on National Defense, supplementary reports of the Board of Trustees E and S, and Resolution No. 25, which was submitted by Dr. J. P. Culpepper Jr., for the Mississippi State Medical Association.

Your reference committee heard a great deal of discussion that gave us a good picture of the present situation with respect to the "Doctor-Draft" law and the problems involved in the maintenance of a high level of medical care for the members of the armed forces. Everyone was in agreement with and stressed the importance of continuing to provide members of the armed forces with the best possible medical care and agreed that this was the primary objective of all concerned. There was, however, considerable difference of opinion in regard to how this could best be accomplished. Your reference committee noted that a special committee of the Council on National Defense is making "an exhaustive study in order to determine the possibilities of increasing the attractiveness of the military reserves and the National Guard for physicians" as requested in Resolution No. 34 introduced in the June, 1954, meeting of the House of Delegates by Dr. Paul D. Foster of California. This special committee is to make its report "at the earliest possible moment." Your reference committee was impressed with the importance and urgency of establishing some more permanent solution to the problem of providing medical services for the armed forces rather than to continue to depend on measures of a makeshift or temporary nature that were made necessary during recent periods of emergent conditions.

Your reference committee learned of the many cooperative efforts that have been made and that are being made by the Council on National Defense and the Department of Defense and its branches and noted the many studies that have been made concerning the need for physicians in the armed forces and the use of these services.

Your reference committee noted that a bill to provide military medical scholarships will be presented to the 84th Congress and also noted many other activities of the Board of Trustees and its Council on National Defense in the interest of providing the members of our armed forces with the best possible medical care. The present "Doctor-Draft" law will expire on June 30, 1955. The Board of Trustees and its Council on National Defense are convinced that an extension of the "Doctor-Draft" law is not needed, since there are many possible alternative methods that can be used to provide the medical care that should be provided for the members of the armed forces. Your committee noted the efforts and the willingness of the Council on National Defense and the Board of Trustees to work with the Department of Defense in this matter and also noted that the Department of Defense has not reached a decision concerning the nature of the legislation it will propose to the 84th Congress on this subject. Your reference committee therefore recommends: (A) That on the basis of current information the House of Delegates commend and express itself as being in complete accord with the Board of Trustees and its Council on National Defense in the opinion that the "Doctor-Draft" law should not be extended after June 30, 1955, and that the House of Delegates further express its confidence in the ability of the Board of Trustees and its Council on National Defense to handle properly any new situation that may develop in regard to this highly complex and involved problem; (B) that the Board of Trustees and its Council on National Defense continue to study the problem of providing the best possible medical service for members of the armed forces and that they make recommendations to the Department of Defense at the earliest possible time for a more permanent solution to the problem, giving special attention to the further development of a career medical corps with adequate compensation therefor.

Civil Defense Activities: This section of your committee's report deals with the report of the Board of Trustees and its Council on National Defense and supplementary report D of the Board of Trustees. Your reference committee noted the many activities that were in the interest of stimulating medical preparedness to meet any wartime or natural disaster. It ascertained that the matter of transferring the civil defense activities of the federal government to the Department of Defense is presently being considered by the Commission on Organization of the Executive Branch of the Government (Hoover Commission).

Your reference committee therefore recommends that the House of Delegates (A) concur in the view of the Board of Trustees that no definite action be taken at this time in regard to a proposal for transferring federal civil defense activities to the Department of Defense; (B) approve the many worth-while activities carried on by the Board of Trustees and its Council on National Defense in the field of civil defense; (C) urge all state and local medical societies in this country to cooperate in every way possible with the medical civil defense preparedness activities of the Board of Trustees and its Council on National Defense.

Physicians in or Released from Military Medical Service: Your reference committee noted the opinion surveys that have been made with physicians discharged from military service. This activity in your committee's opinion has been an excellent contact with these physicians and has yielded much valuable information. Your committee noted the physician placement activities that have accrued to the benefit of communities and medical institutions in need of physicians and to the physicians who have been released from military service. Your committee calls to your attention the new liaison that is being maintained by the American Medical Association with physicians now on active military duty and the splendid cooperation of the Department of Defense in all these activities. Your attention is called especially to the publication in the *U. S. Armed Forces Medical Journal* of an unedited article each month. The articles are prepared and submitted by the Council on National Defense and are entitled "A Message from the A. M. A."

Your reference committee therefore recommends that the House of Delegates (A) express its appreciation to the Board of Trustees and its Council on National Defense for these efforts and urge that they be continued; (B) express its appreciation to the Department of Defense for its splendid cooperation in these activities.

Miscellaneous: Your reference committee noted the change in the name of the Council from the Council on National Emergency Medical Service to the Council on National Defense, and believes this change in name was wise and that it has eliminated much of the confusion that previously existed in connection with the name. Our attention was called to (A) the splendid services rendered by the late Dr. James C. Sargent, who served as chairman of the Council on National Defense from the time of its inception until his death; (B) the splendid services of Mr. C. Joseph Stetler who is now director of the Law Department of the American Medical Association; (C) the splendid services of Dr. W. J. Baker, who was forced to resign from the Council on National Defense because of illness.

Your reference committee therefore recommends that the House of Delegates (A) express its appreciation for the fine services rendered by the late Dr. James C. Sargent and by Dr. W. J. Baker and Mr. C. Joseph Stetler; (B) express its appreciation to the Board of Trustees and the present members and staff of the Council on National Defense for their splendid work and for the excellent reports they have submitted.

REPORT OF REFERENCE COMMITTEE ON INSURANCE AND MEDICAL SERVICE

Dr. William M. Skipp, Ohio, submitted the following report, which was adopted:

Your Reference Committee on Insurance and Medical Service had referred to it the report of the Council on Rural Health. This report covers a 10 year period since the creation of the first Committee on Rural Health. The members are very grateful for the change of status from a committee to a council. The

work carried on in 1945 was very disheartening, because all the farm organizations did not know where to look for help and were afraid of help offered by the Association. Through the bringing together of all the leaders of farm organizations and the giving of worth-while advice, these leaders now look to the Council for help.

The country has been divided into sections, all working together with various subcommittees working under the Council. Woman's auxiliaries and state and county societies have cooperated, so that the views of all are presented and understood. Medical scholarships have been set up in several states to get young men back to these areas. Special training programs have been established for rural practitioners over the country. Special "student days" are now operating in medical colleges, explaining to students the need and benefits derived from rural practice. Rural health committees are writing articles for farm publications and newspapers. Prepaid medical care plans of various farm organizations, such as the National Grange, are understood and supported.

The Field Director has assisted with, and taken part in, conferences on how farm organizations can better develop better health programs. No resolutions have been posted criticizing the American Medical Association by any local or national farm organization. Thousands of pieces of informative material have been prepared and distributed for the benefit of the farm people.

Your reference committee recommends that this report, wherein the great amount of work done by the Council and its various district subdivisions is reported, be read by the entire membership of the House of Delegates.

REPORT OF REFERENCE COMMITTEE ON SECTIONS AND SECTION WORK

Dr. Donald C. Conzett, Chairman, submitted the following report, which was adopted:

In regard to the report of the Council on Scientific Assembly, your reference committee calls your attention to the fact that this is the first report from the Council since its reorganization that now includes the Bureau of Exhibits. Your committee especially commends the singular contribution of Dr. Thomas G. Hull, director of the Bureau for many years and now the Secretary of the Council. In addition the creative efforts of the members of the Council are apparent in this splendid report that is largely informational. Your committee commends the Council for its attraction of industry into the elaboration of the use of visual aids in postgraduate education. The high level of the scientific programs reflects the cooperation of the Council with the Local Committee on Arrangements. We feel it is desirable that flexibility in arranging meetings continue to be allowed the local group in their planning. The foresight of the Council in planning a program on angiology meets with our encouragement and reffects its wisdom in the choice of topics on the frontiers of knowledge.

In noting the rules regarding the published reproductions of panel discussions your committee calls your attention to rule 2, which now states, "Permission should be obtained from the participants as well as from the Council on Scientific Assembly," and urges that the wording be changed from "should" to "must" in order to protect the contribution of the individual. The remainder of the rules seem adequate and inclusive.

Your committee is in agreement with the Council in its decision to defer the request of the American Association of Public Health Physicians for the establishment of a separate section. No member of this organization appeared at the hearings of the committee.

The descriptions of the meetings in both St. Louis and San Francisco indicate the changing pattern of the scientific assemblies. The growth of the question and answer conferences, the manikin demonstrations, the fracture exhibitions, and the demonstrations in pathology can be attributed to the nutrition of personal interest. The great success of these educational ventures seems to lie in the fact that it invites personal contact with the physician for exploration of his problems. The personal interest and fatiguing efforts of such men as Gordon M. Morrison, Howard F. Root, Richard Paddock, Frank B. Queen, Gerson R. Biskind, Ralph G. Carothers, Howard P. Lewis, and Herbert W. Virgin Jr., and their associates too numerous to mention by name, demand our sincere admiration.

The work of the California Medical Association in tape recording of lectures now available at nominal cost is another step forward in postgraduate education for even the remote person. The extension of the use of tape recordings seems to your committee to offer a unique form of record that greatly enhances the resources of educational techniques. Your committee is pleased to note in these changing times that a greater use of all exhibits is bettering our relations with the public. The amazing use of these facilities in museums, fairs, and expositions indicates an expanding attitude toward the philosophy that our major concern is the promotion of health. The increasing use of motion pictures seems to follow the growth of the film library, and the reviews of these new films published in THE JOURNAL enable the county and state societies to choose intelligently material for their programs. In all of this your committee understands that the particular force of Mr. Ralph Creer is to be commended.

Supplementary Reports of Board of Trustees

Dr. Dwight H. Murray, Chairman, presented supplementary reports of the Board of Trustees A to T, which were referred by the Speaker to reference committees as indicated.

A. RESOLUTION ON RECORDING OF SCIENTIFIC LECTURES

In June, 1954, the House of Delegates adopted the resolution introduced by Dr. Wendell C. Stover, Indiana, authorizing the Council on Scientific Assembly to conduct a thorough study of the use of tape recordings of material presented at the meetings of the Scientific Assembly. In accordance with the action of the House of Delegates, the Council has instituted an investigation of all phases of the problem. Sufficient time, however, has not elapsed to permit an evaluation of such recordings in the field of graduate medical education. It is the recommendation of the Board of Trustees, therefore, that an additional period of time be allowed the Council on Scientific Assembly to continue its study before submitting definite conclusions on the subject to the House of Delegates.

B. RESOLUTION ON CHANGING TIME OF SECTION MEETINGS

In accordance with the request of the House of Delegates, the Council on Scientific Assembly considered the resolution introduced by Dr. Hollis E. Johnson, Section on Diseases of the Chest, which instructed the Council to explore the possibility and ways and means of changing the scientific section meetings from the last three days to the first three days of each meeting of the American Medical Association. In its report to the Board of Trustees, the Council indicated that it is aware of the difficulties of scheduling meetings during the latter part of the week of the Annual Meeting but feels that a change at this time is not desirable. In this opinion the Board of Trustees concurs.

Supplementary reports A and B were referred to the Reference Committee on Sections and Section Work.

REPORT OF REFERENCE COMMITTEE ON SECTIONS AND SECTION WORK

Dr. Donald C. Conzett, Chairman, presented the following report, which was adopted:

Regarding supplementary report A, your committee hopes that the Council on Scientific Assembly will continue its evaluation of tape recordings in the field of graduate education and be prepared to submit its definite conclusions in June, 1955, at Atlantic City.

Supplementary report B, which deals with the changing of the time of section meetings, was thoroughly discussed. This is a big problem, as the element of proper timing is important in all human efforts. The facets of the problem outstrip the diamond in number: there is the problem of the meetings of special societies that precede the American Medical Association meeting and trying to hold them over for the following week; the problem of the total number of days that any physician can afford for medical meetings; the psychological impact of the week-end move for home that depletes the meeting rooms on Fridays; and

finally the problem that a high level of performance on the first three days of a week may be superior to the five day meeting that often requires padding.

Even though the Council feels "that a change at this time is not desirable," and in which opinion the Board of Trustees concurred, it should be noted that a partial solution to this problem has evolved, namely, that the section meetings are now planned to begin on Tuesdays.

C. Resolution on Legalization of Narcotics

In accordance with the directive of the House of Delegates in June, 1954, the Board of Trustees referred to the Council on Pharmacy and Chemistry for detailed consideration the resolution introduced by Dr. Andrew A. Eggston, New York, which favored the distribution of narcotics at cost or free under several safeguards.

The Council, following consultation with several individuals and groups active in this field, agrees that the narcotic problem has increased in seriousness since the close of World War II. The means of alleviating the problem, as suggested by the resolution, was extensively tried during the period after the end of the first World War. Experience with these clinics clearly indicated that they were an absolute failure and that they increased rather than diminished the problem. The evidence on this point was so clear that those who had originally advocated them were convinced, and all of the clinics were closed within a few years. However, the Council feels that the present situation is far from satisfactory and that the problem is being handled too exclusively as a police problem, without sufficient emphasis on its most important medical aspects.

The Board considered the report of the Council on Pharmacy and Chemistry, as well as pertinent material from the National Research Council and the Commissioner of Narcotics, and recommends that the resolution introduced by Dr. Eggston be not adopted. The Board, however, believes that the matter should be thoroughly explored and is referring the problem to the Subcommittee on Narcotic Addiction of the Council on Mental Health.

Supplementary report C was referred to the Reference Committee on Hygiene, Public Health, and Industrial Health.

REPORT OF REFERENCE COMMITTEE ON HYGIENE, PUBLIC HEALTH, AND INDUSTRIAL HEALTH

Dr. Warde B. Allan, Chairman, presented the following report, which was adopted:

Your Reference Committee on Hygiene, Public Health, and Industrial Health had two matters referred to it, one being supplementary report C of the Board of Trustees, entitled Resolution on Legalization of Narcotics. Your reference committee recommends the adoption of this report.

D. Transfer of Civil Defense Activities to Department of Defense

In accordance with the directive of the House of Delegates in June, 1954, the Board of Trustees considered the resolution introduced by Dr. Paul D. Foster, California, which recommended the abolition of the Federal Civil Defense Administration and transfer of its functions to the Department of Defense, and a lengthy report from the Council on National Defense to which the resolution was referred, as well as other pertinent information in this regard.

In view of the fact that the Commission on Organization of the Executive Branch of the Government (Hoover Commission) has had this matter under study, and the further fact that its report will be forthcoming in the near future, the Board recommends that no definite action be taken on the resolution until it has had an opportunity to review the report of the Hoover Commission.

E. Resolution on "Doctor-Draft" Law

At the June, 1954, meeting of the House of Delegates, Resolution No. 34 was introduced by Dr. Paul D. Foster, California. The resolution recommended a number of long-range programs designed to provide methods of solving the needs of the armed services for medical personnel and was referred to the Council on National Defense "for exhaustive study in order to determine the possibilities of increasing the attractiveness of the military reserves and the National Guard for physicians." The resolution was considered by the Council on National Defense, and it was decided that, in view of the involved and complicated nature of the resolution, a special committee of the Council be appointed to conduct an exhaustive study recommended by the House of Delegates and that this committee report back at the earliest possible moment.

As soon as the Council on National Defense presents its findings and recommendations to the Board of Trustees, a report will be submitted to the House of Delegates.

S. American Medical Association Policy on the "Doctor-Draft" Law

In considering the position of the American Medical Association relative to the extension of the "Doctor-Draft" law beyond June 30, 1955, the Association would like to emphasize that the physicians in this country have continually demonstrated their willingness to serve their country in time of need. The medical profession is, nevertheless, vigorously opposed to the further extension of discriminatory legislation of this type.

It is the recommendation of the American Medical Association that the "Doctor-Draft" law be discontinued as of June 30, 1955. It is the belief of the Association that a sufficient number of physicians can be secured to satisfy the legitimate needs of the armed services through alternative methods. It is recognized that some "minor" amendments to the basic Selective Service Act may be required assuming, of course, that the basic Selective Service Act is extended beyond its current expiration date of June 30, 1955. Such amendments would probably include a provision permitting a "selective" call-up of physicians who have an obligation for military service under the general Selective Service Act and who have been deferred in order to complete their medical education. Such a provision would not increase a physician's liability in terms of age requirements and would not subject him to the discriminatory features of the present law.

Supplementary reports D, E, and S were referred to the Reference Committe on Medical Military Affairs. The report of that reference committee on supplementary reports D, E, and S will be found in its report following the report of the Board of Trustees on page 1599 of this issue of The Journal.

F. Resolution on Membership Procedures in Security Risk Cases

In accordance with the recommendation of the House of Delegates, the Board of Trustees, after consultation with legal counsel, considered the resolution introduced in June, 1954, by Dr. John P. Culpepper Jr., Mississippi, on membership procedures in security risk cases. This resolution is designed to withhold membership privileges from physicians discharged from military service for "reasons proved to be inimical to the security of the United States." The Board notes that the resolution applies to only a small segment of the medical profession, those discharged from military service for security reasons, and does not apply to civilian physicians.

It is the belief of the Board of Trustees that attention should be invited to the fact that the medical profession has consistently shown itself to be a loyal segment of the citizenry of the United States. The American Medical Association and its component and constituent societies have always done everything in their power to promote the highest degree of national loyalty among their membership. It is felt advisable to call attention again to section 1 of chapter VIII of the Principles of Medical Ethics, which states, in part:

> Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity.

G. Resolution on American Medical Association Service Memberships

The Board of Trustees, in compliance with the action taken by the House of Delegates in June, 1954, on the Colorado resolution on American Medical Association Service Memberships, conducted a survey of physicians in the armed forces through the

Surgeons General of the Army, Navy, Air Force, and Public Health Service and the Chief Medical Director of the Veterans Administration. It is the belief of the Board, after studying the results of the surveys, that the present system should not be changed, since it would immediately result in a large loss of membership due to the inability of many physicians in the armed forces and the Veterans Administration to qualify for one reason or another for membership in a county medical society. Furthermore, the surveys indicate that the vast majority of the present service members desire that the system be retained without change. For these reasons the Board of Trustees recommends that the resolution be not adopted.

L. Problems in the Field of Oral Surgery

The special committee appointed by the Board in compliance with the June, 1954, action of the House of Delegates to study problems in the field of oral surgery, met in Miami on Nov. 27. The meeting was attended by four members of the Committee, Drs. Walter B. Martin, Leonard W. Larson, Paul W. Greeley, and Gunnar Gundersen and, by invitation, Dr. Gordon F. Harkness and Mr. Robert B. Murphy. The following report of that meeting is submitted by the Board for action by the House of Delegates:

The general problems of the field of study were reviewed in detail, particularly as they referred to the action of the House of Delegates at its meeting in June, 1953, in adopting the following statement:

". . . that the oral (dental) surgeon be assigned to a surgical service of a hospital and perform such professional duties as the chief of the surgical service directed.

"Dental-oral surgery is to be limited to the diseases of the teeth and jaws and lesions of contiguous soft tissue related to diseases of the teeth and jaws but excluding malignancies."

Subsequent to this action, a rule was laid down by the Joint Commission on Accreditation of Hospitals defining the place of the oral surgeon in the hospital.

In April, 1954, at a meeting of the group representing the dental and oral interests, the following definition, adopted by the American Dental Association in September, 1953, was accepted by the committee of the Board composed of Drs. Leonard W. Larson, E. J. McCormick, and Gunnar Gundersen:

"The specialty of oral surgery is that part of dental practice which deals with the diagnosis, the surgical and adjunctive treatment of the diseases, injuries, and defects of the human jaws and associated structures.

"The scope of the specialty of oral surgery shall include the diagnosis, the surgical and adjunctive treatment of the diseases, injuries, and defects of the human jaws and associated structures within the limits of the professional qualifications and training of the individual practitioner and within the limits of agreements made at the local level by those concerned with the total health care of the patient."

This report received the approval of the Board of Trustees and was submitted to the House of Delegates at its meeting in San Francisco in June, 1954. At that time the Reference Committee on Medical Education and Hospitals recommended that (1) no action be taken in regard to the definition approved by the Board, and (2) that the Board of Trustees appoint a committee representing all interests involved, including the Section on Laryngology, Otology, and Rhinology, for the purpose of developing mutual understanding and agreement in regard to this important matter. The reference committee report was adopted by the House.

At the meeting on Nov. 27, the opinion was expressed that the present committee was not completely fulfilling the mandate of the House in that sufficient representation of all interested groups was not present, which precluded the attempt to reach an amicable settlement.

As a result of the meeting, the recommendations of the Committee are that only progress be reported at this time and that further meetings of the Committee be held, inviting, particularly, representatives of the groups officially representing the maxillofacial surgeons and the dental profession for the purpose of reaching, if possible, a common understanding with respect to a definition of dental-oral surgery.

N. The World Medical Association

The eighth annual general assembly of the World Medical Association was held in Rome, Italy, during the latter part of September and the first of October of this year. Those who attended will remember forever the beautiful buildings in which the Association's officers, delegates and visitors met and were entertained. Italy long has been known for the warmth and friendliness of its people, but only those who experienced this can fully appreciate the courtesy and kind attention shown at this meeting. Entertainment for the visitors seemed to be the order of the day, and yet in spite of this much work was done.

Among the topics discussed were cost of medical care, human experimentation, supply of doctors, use of drugs, medical ethics, medical education, and occupational health. Considerable discussion was devoted to the first World Conference on Medical Education, which was held in London, 1953, under the auspices of the World Medical Association. Plans also were revealed for a second such conference, this one to be held in North America in 1959. The proceedings of the 1953 conference are now available in book form from the Oxford Press. Also discussed with much interest were the plans for a World Conference on Occupational Health under the auspices of the W. M. A. This will be held within the next few years. Details of this and other World Medical Association activities will appear in the *World Medical Journal.*

The World Medical Association is a young organization, being only eight years old, but it already has exerted influence on world affairs of a medical nature. Whether the subject is scientific, economic, or political, if it involves medicine, the World Medical Association is actively interested. This is possible because of the support given to it by national medical associations and because it is free of government control. Unfortunately, the World Medical Association is still confused by some people with the World Health Organization. This is unfortunate, because the former consists of national medical associations and their members and the latter is made up of representatives of government. This difference is of fundamental importance to the physicians of the world and to their patients. Physicians in North America enjoy a type of freedom not always found in other countries. And yet physicians throughout at least the free part of the world are united in their desire to give the best possible medical care without being hampered by bureaucratic control as they discharge their duties.

The financial affairs of the World Medical Association have always been a matter of concern, because the growth of the Association threatens to outrun the financial sources. The physicians of America, members of the drug industry, and some other well-wishing supporters have provided much help over the past eight years. This has been necessary for several reasons, one important reason being the difficulty of transferring funds from some countries. The American supporters have been banded together in what is known as the United States Supporting Committee. This program, which has been helpful here, is now being developed in other countries, for example, Canada, Great Britain, Switzerland, Sweden, and the Philippines. Other countries have organized or are about to organize similar committees. Their full effectiveness will not be felt, however, for several years, and it therefore remains urgent for many more physicians in the United States to join the United States Supporting Committee. Dues are only $10, for which the member receives the *World Medical Journal* and considerable other material. Dues can be paid to the office at 345 E. 46th St. in New York City and are a sound investment in the preservation of freedom of medical practice. If one doubts this he has only to inform himself of some of the socialistic proposals offered by the International Labour Office and the International Social Security Association and to look at the record of the World Medical Association in standing up to such proposals. The World Medical Association has an enviable record behind it. Its future depends to a large extent on the support given to it by physicians such as those in this House of Delegates.

At the eighth assembly, Dr. Edwin S. Hamilton was elected to succeed Dr. Austin Smith as a member of the Council of the World Medical Association. Dr. Smith's term of office had expired. He continues to serve the World Medical Association as its executive editor. The other member of the Council from the United States is Dr. Gunnar Gundersen, also of your Board of Trustees.

The next meeting, the ninth general assembly, will be held in Vienna, Austria, in 1955. It is not too early for those who wish to attend to begin making their plans now.

O. Report of Committee on Blood

National Blood Foundation: The Committee on Blood can report that great progress has been made since its last report on the National Blood Foundation. It is hoped that by the time of the next report organization of the National Blood Foundation may be an accomplished fact.

During the fiscal year ending June 30, 1954, the American National Red Cross reports 1,084,448 donations of blood for defense purposes and 1,764,921 donations for civilian use. Due to the cancellation of contracts with cooperating private blood banks by the American National Red Cross at the end of the Korean police action, only 27,999 defense donations were from private blood banks. The Committee on Blood does not have statistics available on the number of blood donations made to private blood banks for civilian use. It is hoped that the contemplated National Blood Foundation may arrange for collection of such data annually.

Gamma Globulin: At the June, 1954, session in San Francisco resolution No. 56, passed by the House of Delegates, charged the Committee on Blood to review the controls and restrictions placed on the distribution of gamma globulin on physicians' prescriptions. Control of the national pool of gamma globulin rested in the Office of Defense Mobilization, which delegated distribution to the states and territories to the Public Health Service. Locally, gamma globulin supplies were controlled by the health department of the area. As of Sept. 30, 1954, the director of the Office of Defense Mobilization, Arthur S. Flemming, announced that the program would be discontinued at the end of 1954 because an increase in supply indicated that all foreseeable demands could be met. Various commercial suppliers made gamma globulin available on physicians' prescriptions through regular medical supply channels on Oct. 1, 1954. The decision of the Office of Defense Mobilization, coupled with release of gamma globulin on physicians' prescription, makes further consideration of Resolution No. 56 unnecessary at this time. However, since the commercial supply of gamma globulin this year will be small as compared to the national pool, the Committee on Blood recommends that the use of gamma globulin for the prophylaxis of measles and infectious hepatitis be given priority by physicians.

State Blood Bank Committees: The Committee on Blood is encouraged by evidence of increased activity in the formation and operation of state blood bank committees. The Committee feels that these state committees on blood should in turn urge the formation of county medical society committees on blood. One of the tasks state committees should undertake is to ascertain whether there is an adequate distribution of blood throughout the state. If there exist areas where supplies of blood for transfusions are inadequate, attempts should be made to encourage formation of facilities for the collection, processing, storage, and distribution of blood supplies in the deficient area. In such an activity, the county medical society plays an important role, since it has been repeatedly emphasized by the House of Delegates of the American Medical Association that local societies are best qualified to decide the type of blood-collecting program suited for their areas. In these programs, special attention should be paid to the problems of small rural hospitals and their integration into a state blood program.

Q. 1957 Clinical Meeting

Invitations for the 1957 Clinical Meeting of the Association were received from Denver, Detroit, Mexico City, Mexico, Philadelphia, and Washington, D. C. Following investigation of the facilities and accommodations of the several cities, the Board of Trustees has chosen Philadelphia as the place for the 1957 Clinical Meeting of the American Medical Association. The date of the meeting will be announced at a later time.

Supplementary reports F, G, L, N, O, and Q were referred to the Reference Committee on Miscellaneous Business.

REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Dr. Frank J. Elias, Chairman, submitted the following report, which was adopted:

Your committee approves of the recommendation of the Board of Trustees in its supplementary report F that the Culpepper resolution, introduced in June, 1954, be disposed of according to the provision of the Principles of Medical Ethics, section 1, chapter VIII.

Your committee recommends the adoption of supplementary report G, which will continue the present system of service memberships in the American Medical Association.

Regarding supplementary report L on Problems in the Field of Oral Surgery, your reference committee believes that no action is indicated in this instance. However, it recommends continued study as advised by the Board of Trustees and that a report be made to the House of Delegates as promptly as practicable.

Your committee concurs in supplementary report N as presented and recommends full support by the medical profession of the World Medical Association.

Your committee approves supplementary report O in principle as presented and wishes to thank Dr. J. Stanley Kenney, delegate from New York, who described in detail the blood bank programs of New York City and the State of New York. Your committee is very much impressed by the plan as outlined by Dr. Kenney and would urge all county and state medical societies to consider the adoption of similar programs.

Your committee recommends that supplementary report Q of the Board of Trustees, in which it was announced that Philadelphia has been chosen for the 1957 Clinical Meeting, be approved.

H. Report of Committee on Medical Practices

At the June, 1954, meeting of the House of Delegates, the Board of Trustees was instructed to appoint a committee to study certain medical practices and related public relations problems. The Board appointed a Committee on Medical Practices under the chairmanship of Dr. Stanley R. Truman. The members are Drs. Felix L. Butte, John S. DeTar, James Q. Graves, Ernest E. Irons, Leland S. McKittrick, and Walter L. Palmer. In conducting its study, the Committee employed Rollen Waterson Associates to perform staff activities. The Committee has now completed its survey and has forwarded its report to the Board. In view of the scope and importance of the matter under consideration and inasmuch as the report was submitted at this meeting, the Board is withholding any comment or recommendations at this time. The report of the Committee will be thoroughly analyzed and will be reported on by the Board of Trustees at the next meeting of the House of Delegates. The Board commends the Committtee and its staff for their work and would like to reserve the right to continue the study if it appears advisable.

J. Report of Special Committee on Rehabilitation

At its December, 1953, meeting, the House of Delegates adopted a resolution concerned with the deletion of the word "rehabilitation" from the names of the American Board, the Section, and the Council on Physical Medicine and Rehabilitation and recommended that a committee be appointed by the Board of Trustees to consider the problem. Following its appointment the committee met and submitted a lengthy report on the four issues involved in the resolution. In submitting this statement to the House in June, 1954, the Board recommended that the report be received as information only and that the committee be continued with instructions to devote further study to the problem and to bring in a report at the December, 1954, meeting. The House of Delegates adopted the recommendations of the Board.

Since that time, the special Committee on Rehabilitation has met, and in its report on the meeting requests that it be continued with the expectation of submitting a full report in June, 1955. The Committee was informed that the Board of Trustees is making a study of the various councils in an effort to correlate their activities and to bring them up to date. Until this study has been completed and necessary changes effected, the special Committee believes that it would be unwise to make any suggestions or recommendations concerning one particular council at this time.

The Board of Trustees is in complete agreement with the report of its special Committee and requests the approval of the House of Delegates.

K. Resolution on Medical Care for Dependents of Service Personnel

In June, 1954, the House of Delegates referred to the Council on National Defense for study and report the resolution introduced by Dr. Samuel J. McClendon, California, dealing with the subject of medical care for dependents of service personnel.

Inasmuch as the Council on Medical Service had previously been given the responsibility of studying the provision of dependent medical care by civilian physicians in civilian institutions, the resolution was referred to it for review. In its consideration of the resolution, the Council on Medical Service held a conference to which were invited representatives from California, the American Hospital Association, the National Medical Veterans Society, the Council on National Defense, the health insurance field, and other persons with particular knowledge of the subject.

The report of the Council in this matter was received by the Board for use as a guide in any discussions on dependent medical care with the Department of Defense.

M. Professional Liability Insurance

Since the initial report was made in 1952 on the subject of professional liability insurance, the Council on Medical Service has been diligent in its study of the over-all problem as well as the specific resolution introduced by Dr. Wendell C. Stover, Indiana, and adopted by the House of Delegates in June, 1953, on the subject of premium rates for insurance on medical partnerships. At this Miami meeting, the Council on Medical Service submitted a report of progress on its activities in this regard, which has been accepted by the Board with the request that it continue its studies in cooperation with the Law Department.

The Board wishes to assure the House that it recognizes the urgency of this matter and that every effort is being made to complete the study so that suitable recommendations may be made.

Supplementary reports H, J, K, and M were referred to the Reference Committee on Insurance and Medical Service.

REPORT OF REFERENCE COMMITTEE ON INSURANCE AND MEDICAL SERVICE

Dr. William M. Skipp, Chairman, presented the following report, which was adopted:

Supplementary Report H on Committee on Medical Practices: Your committee considered this report and approves the recommendation of the Board of Trustees that the study be continued.

Supplementary Report J on Report of Special Committee on Rehabilitation: Your committee considered this report and approves the recommendation of the Board of Trustees that the study be continued.

Supplementary Report K on Medical Care of Dependents of Service Personnel: Your reference committee recommends that if it is to be the policy of the government to provide for medical care for dependents of service personnel, the services of civilian physicians and hospitals be used wherever possible, to be paid for at prevailing rates with provision for free choice of physicians.

Supplementary Report M on Professional Liability Insurance; Resolution No. 6 on Physicians' Liability Insurance, and Resolution No. 7 on Malpractice Insurance: All three were considered together, as they dealt with the same subject. Inasmuch as the Board of Trustees has reported that there is in progress a study on the subject, your reference committee feels that we can well await the recommendations the Board is planning to make at the next session. Due to the apparent emergency aspect of the problem, the Board of Trustees is urged to report to the membership as soon as possible, through its component societies, on the progress of this urgent study.

I. Resolution on Establishment of Council on Medical Care

The Board of Trustees, following the action of the House of Delegates in June, 1954, considered the advisability of the establishment of a council on medical care as suggested by the resolution introduced by Dr. Raymond F. McKeown, Oregon.

It is the considered opinion of the Board that working relationships have already been developed by the Council on Medical Service, the Committee on Relations Between Medicine and Allied Health Agencies, and other units within the American Medical Association with the various groups mentioned in the resolution and that the wholly desirable objectives of the McKeown resolution are therefore now in large part being realized. For this reason, the Board believes that a new council on medical care is not necessary.

R. Contribution to American Medical Education Foundation

The Board of Trustees wishes to call specific attention to the Statement of Expense Comparison of the councils, bureaus, committees, and selected departments of the Association for 1950-1955. It will be noted that this statement indicates a substantial increase in the funds allocated to all departments in order to carry on the activities that in numerous instances have been undertaken because of the additional duties imposed through actions and directives of the House of Delegates.

With the condition of the budget in mind, the Board gave serious consideration to the contribution of the Association to the American Medical Education Foundation, which has been $500,000 a year for several years. This year the Board wishes to announce that the donation of the Association can be only $100,000, and, that unless our income is substantially increased, it will not be possible to allocate any funds for the Foundation in succeeding years, without undermining our reserves.

Supplementary reports I and R were referred to the Reference Committee on Reports of Board of Trustees and Secretary.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF BOARD OF TRUSTEES AND SECRETARY

Dr. Eugene F. Hoffman, Chairman, submitted the following report, which was adopted:

Supplementary Report I: Your committee concurs with the Board of Trustees that the aims of this resolution are now in a large part being realized and believes that a new council on medical care is not necessary.

Supplementary Report R: Your committee regrets that the Board of Trustees has found it necessary to reduce the donation to the American Medical Education Foundation to $100,000. A review of the Statement of Expense Comparison will clarify the logic behind this action. However, the committee feels that this project should be largely taken over by the state associations supplemented by individual donations.

P. Report of Committee to Study Relations Between Osteopathy and Medicine

Contingent on the receipt of the report from the Committee to Study the Relations Between Osteopathy and Medicine of its "on campus" observations of osteopathic schools, the House of Delegates in June, 1954, agreed to hold in abeyance any action on this important subject until this meeting.

The Committee, after meetings and extensive negotiations with the American Osteopathic Association, has now made final arrangements for visiting five of the six schools of osteopathy, and these plans have been approved by the Board of Trustees. It is the recommendation of the Board, therefore, that consideration of this matter be held in abeyance by the House of Delegates until the June, 1955, meeting, at which time the Committee expects to have a complete report of its findings concerning the nature, scope, and quality of education in schools of osteopathy.

Supplementary report P was referred to the Reference Committee on Medical Education and Hospitals.

REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Dr. Walter P. Anderton, Chairman, presented the following report, which, after discussion and a motion to amend was defeated, was adopted:

Supplementary Report P on Report of Committee to Study the Relations Between Osteopathy and Medicine: Your reference committee concurs in the recommendations in the supplementary report of the Board of Trustees that a complete report be submitted in June, 1955.

T. Resolution on Death of Dr. James C. Sargent

The following supplementary report T was adopted, without referral, by a unanimous standing vote:

As many of you know, Dr. James C. Sargent, Chairman of the Council on National Defense, died suddenly on Oct. 7 of this year. The following resolution, adopted by the Council at its meeting on Oct. 23 and 24, was approved by the Board of Trustees for transmittal to the House of Delegates:

Whereas, The untimely and sudden death of Dr. James C. Sargent on Oct. 7, 1954, in Detroit has taken from the profession and this Council a much-beloved and respected fellow physician; and

Whereas, For many years Dr. Sargent served faithfully and diligently as the chairman of the Council on National Defense of the American Medical Association, being one of the original members of the Council when it was established in 1947; and

Whereas, Through his demise the Council has suffered a grave loss because of his keen and sustained interest in the medical and health problems of the country in the event of a national emergency and in medical civil defense affairs, and for his immeasurable contributions and untiring efforts in these endeavors; therefore be it

Resolved, That the Council on National Defense and the Board of Trustees do hereby express to the House of Delegates of the American Medical Association its deep sorrow and profound loss of a capable chairman and inspiring friend.

Special Report of Judicial Council

Dr. Homer L. Pearson Jr., Chairman, presented the following special report of the Judicial Council, which was referred to the Reference Committee on Miscellaneous Business:

Dr. Edward R. Cunniffe

The retirement in June, 1954, of Dr. Edward R. Cunniffe from the Judicial Council of the American Medical Association, after 18 years of dedicated service, occasioned a deep sense of regret among his associates both on and with the Council. Faithful in his attendance and devoted and impartial in seeking equity and justice in consideration of appeals, of complaints, or of requests for information or service coming before the Council, Dr. Cunniffe as a member of the Council or as its chairman won and held the respect and affection of all connected with the affairs of the Council.

The duties of the chairman, by reason of the widely varied correspondence occurring between meetings of the Council, are more onerous than those of other Council members. Therefore, the members of the Judicial Council heartily unite in this brief tribute by bringing to the attention of the general officers and the members of the House of Delegates the long and distinguished service of "Eddie" Cunniffe to the American Medical Association.

REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Dr. Frank J. Elias, Chairman, submitted the following report, which was adopted by a unanimous rising vote:

Special Report of Judicial Council Concerning Dr. Edward R. Cunniffe: Your reference committee approves this report and is happy to join with the House of Delegates of the American Medical Association in extending this tribute to Dr. "Eddie" Cunniffe for his long and distinguished service.

Report of Judicial Council

Dr. Homer L. Pearson Jr., Chairman, read the following report of the Judicial Council, which was referred to the Reference Committee on Miscellaneous Business:

During the year 1954, the Judicial Council of the American Medical Association has held five meetings divided into 14 sessions. During these meetings, the Council considered applications for service and affiliate membership in the Association, gave its attention to inquiries relating to the interpretation and application of the Principles of Medical Ethics, and heard and decided five appeals from decisions of component and/or constituent medical societies. In two of these appeals, the issue concerned the right to membership in component medical societies, and, in three, the issue pertained to disciplinary action by the component society.

Definitions of Unethical Conduct

The Judicial Council has been asked on numerous occasions to define expressions not used in the Principles of Medical Ethics that connote unethical conduct. The Council does not believe it is appropriate to define such terms, because neither definition nor description determines the ethical nature of conduct. The principles themselves are the criteria by which the ethical nature of professional conduct is determined. Whenever it becomes necessary to evaluate the ethical quality of professional conduct, the answer is to be found in the principles, not in rules or definitions. Thus the Council bases its opinions and interpretations on the Principles of Medical Ethics rather than on extraneous definitions.

Joint Statement of Ophthalmologists

Because of the disproportionate number of requests for opinions of the Judicial Council regarding the ethics of practices in the field of ophthalmology, the Council at one of its meetings late in 1953 adopted a proposal that it should write to the Section on Ophthalmology of the American Medical Association, the American Academy of Ophthalmology and Otolaryngology, and the American Ophthalmological Society calling attention to this situation and ask for a statement regarding the position of these organizations in regard to ophthalmalogists who, in addition to their professional fee for services rendered, make a profit from the sale of glasses to their patients or from the services of any employee in or out of the ophthalmologist's office.

A letter was directed to each of these organizations advising that the queries about ophthalmologists include various techniques related to forms of rebate between optical houses and ophthalmologists or the ethics involved in the employment by an ophthalmologist of an optician or optometrist in his office. It was pointed out that the position taken by the Judicial Council in response to such requests was always on the familiar provisions of section 6 of chapter I of the Principles of Medical Ethics of the American Medical Association, which limit the source of the physician's professional income to professional services rendered the patient without additional compensation secretly, openly, directly, or indirectly from any other source. The letter expressed the belief of the members of the Judicial Council that if the three organizations addressed would take a stand on this situation, it might have a stabilizing effect on the ophthalmologists who are tempted to engage in unethical practices.

A Joint Committee of the Section on Ophthalmology of the American Medical Association, the American Academy of Ophthalmology and Otolaryngology, and the American Ophthalmological Society has submitted the following statement:

Ophthalmologists are subject to all the principles of medical ethics of the American Medical Association. But in order to clarify certain of these principles in relation to the specific practice of ophthalmology, the following statements are considered advisable:

According to a resolution passed at the executive session of the Section on Ophthalmology of the American Medical Association on July 4, 1946 . . . It is within the definition of medical ethics for . . . (ophthalmologists) to engage in lectures, demonstrations, the preparation of pamphlets, and other measures suitable for the dissemination of information designed to prevent blindness and directed to any nonmedical group.

The dispensing of glasses should be considered in the same light as that of writing prescriptions for medicine or in the light of the relationship between the orthopedist and the brace maker.

Ophthalmologists cannot ethically provide glasses for their patients unless the service is unavailable without hardship or inconvenience to the patient.

It is unethical for ophthalomogists to profit from the sale of glasses.

Ophthalmologists cannot derive income from merchandising and still be considered on a professional level.

Ophthalmologists may not accept rebates from optical houses.

It is unethical for an ophthalmologist to profit from the services of an optician, working either in his office or on a referral basis.

Fee splitting, in any form, is unethical whether it be with a physician, optician, optometrist, or a firm engaged in furnishing instruments, drugs, apparatus, laboratory work, or Roentgen Ray examination for an ophthalmologist.

However, when an insurance company pays a lump sum for a service, each doctor who shares in doing the job should share or prorate the fee in proportion to how much work each did, providing it is all clearly stated to the company and to the patient.

Rules of the Judicial Council

During the year the Judicial Council adopted the following rules, which are submitted for the information of the members of the House of Delegates. Rules of the Judicial Council, last adopted in 1912, have been modified from time to time. These rules, adopted Oct. 1, 1954, are, in effect, a revision of the 1912 rules. They do not represent any significant departure from established procedure.

Rules of the Judicial Council of the American Medical Association

Rule 1. Administration.

A. Meetings: The Judicial Council will meet during the Annual and Clinical Meetings of the American Medical Association. Other meetings of the Council may be called, on reasonable notice, by the chairman of the Council; or they shall be called, on reasonable notice, by the Secretary of the American Medical Association on the written request of at least three members of the Council.

B. Chairman: The Judicial Council shall elect from among its members a chairman and vice-chairman each year at the meeting of the Council held during the Annual Meeting of the Association. Each shall retain the right to vote on all matters.

C. Quorum: Three members of the Judicial Council shall constitute a quorum, but a majority vote of the entire Council shall be required to adopt any action.

Rule 2. Applications for Membership.

A. Active, Associate, and Service Membership: Applications for active, associate, or service membership in the American Medical Association will be considered by the Judicial Council at any meeting upon presentation of the applications by the Secretary of the Association.

B. Affiliate Membership: Applications for affiliate membership submitted by physicians who are members of the chartered national medical societies of foreign countries adjacent to the United States or by American physicians who are located in foreign countries and engaged in medical missionary and similar educational and philanthropic labors will be considered at any meeting of the Judicial Council or presentation of the applications by the Secretary of the Association. The Council will consider and approve only those applications that are accompanied by a statement of a responsible and qualified person attesting to the above set forth requirements.

C. Refusal of Approval: An applicant for membership in the American Medical Association whose application has not been approved by the Judicial Council will be promptly notified of such fact and will be given 20 days within which to request reconsideration of his application in accord with the provisions of rule 3.

Initiation of Proceedings

Rule 3. Reconsideration of Applications for Membership. A request for reconsideration of a refusal to approve an application for membership should be initiated by a written statement setting forth the reasons for reconsideration.

Rule 4. Original Controversies. Original proceedings before the Judicial Council shall be initiated by a written statement. Such statement shall include information (1) identifying the parties to the controversy, including membership affiliations, if applicable, and (2) explaining the nature of the controversy, setting forth the provisions of the Constitution, Bylaws, Rules, or Principles of Medical Ethics concerned.

Rule 5. Appeals. Appellate proceedings before the Judicial Council shall be initiated by a written statement of appeal. Such statement shall include information (1) identifying the parties to the case and indicating membership affiliations when appropriate, (2) showing that the appellant has exhausted remedies made available by the constitution and bylaws of the component society and the constituent association, and (3) describing the error of law or procedure that is believed to have occurred during the proceedings. The statement shall also include a concise, factual resume of the case. Appellant shall submit with the statement the charges, complaints, findings, opinions, and decisions previously entered in the case.

Rule 6. Interpretation of the Constitution, Bylaws, Rules, and Principles of Medical Ethics of the American Medical Association.

A. Requests for Interpretation: Requests for interpretation of the Constitution, Bylaws, Rules, or Principles of Medical Ethics of the Association shall be in writing and shall describe the matter to be interpreted in sufficient detail to enable the members of the Judicial Council to evaluate the request in all its aspects.

B. On Own Motion: The Judicial Council, on its own motion, may render an opinion concerning the interpretation or application of the Constitution, Bylaws, Rules, or Principles of Medical Ethics of the Association and may, on its own motion, consider and decide the constitutionality and validity of all rules and regulations adopted by Councils and Committees of the Association pursuant to the Bylaws of the Association.

C. Discretionary Power: The Judicial Council may, in its discretion, refuse to consider requests for interpretation of the Principles of Medical Ethics that in the opinion of the Council should be resolved by a component society or a constituent association. Requests for interpretation of the Principles of Medical Ethics that are not of national interest and relate to the observance of local customs and ideals may be readdressed to the component society or constituent association primarily responsible for knowledge of the requirements of such local customs and recognized ideals.

Rule 7. Jurisdiction. The Judicial Council may, on its own motion or on the motion of any party, determine the question of jurisdiction at any stage of the proceedings.

Disposition

Rule 8. Additional Statements and Record. The other parties shall have an opportunity to file a brief statement in opposition to the statement filed by the initiating party. Such statement shall be filed within 30 days after the filing of the initiating statement. Additional time may be allowed in the discretion of the Council. The Judicial Council may thereafter require the parties to submit such transcripts of testimony, records, or written statements supporting their contentions or other material as the Council may deem necessary.

Rule 9. Hearings.

A. Notice of Hearings: The Council may, in its discretion, determine whether a hearing is necessary or advisable. The Council will designate the time and place for all hearings, giving reasonable notice thereof to all parties.

B. Attendance: The attendance at hearings may be limited to the members of the Judicial Council, the staff, witnesses, if any, and the parties and counsel who may speak in their behalf. Should any party to the controversy fail to appear, the Council may, in its discretion, continue, dismiss, or decide the matter.

C. Evidence and Argument: The Judicial Council will not be bound by technical rules of evidence usually employed in legal proceedings but may accept any evidence it deems appropriate and pertinent.

In any appeal case, the review, if any, of the evidence will be limited to the evidence presented in the proceedings before the component society and constituent association or appropriate committee, board, or group thereof; provided, however, that in the event the Council is of the opinion such evidence is inadequate to determine the question of law or procedure presented, the Council, on its own motion or on the suggestion of any

party, may require the production of additional evidence before the Council or refer the matter to the appropriate body for additional evidence.

In matters other than appeal cases, the Judicial Council will grant the parties the right to present evidence to the extent the Council believes appropriate to the particular matter in controversy.

In all hearings, the Council, within reasonable limitations, will allow oral argument.

D. Record: In hearings of original controversies, and appeals and in other proceedings, a transcript may be made at the discretion of the Council.

Rule 10. Opinions: All opinions or decisions of the Judicial Council shall be in writing. Copies of the opinion or decision and the dissent, if any, will be filed as a part of the record and furnished to all the parties involved.

Rule 11. Filing and Copies: Eight copies of all documents shall be submitted to the Executive Secretary of the Judicial Council. One copy of each document shall be submitted at the same time to each of the other parties to the controversy.

Conclusion

Owing to the length of this report, the Council respectfully defers comment on subjects that, in the light of the above, may be considered to be of lesser importance.

REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Dr. Frank J. Elias, Chairman, submitted the following report, which was adopted:

Report of Judicial Council: Your committee approves of the first paragraph and recommends that it be accepted by the House of Delegates.

Your reference committee joins with the Judicial Council in its belief that its opinions and interpretations should be based on the Principles of Medical Ethics rather than on extraneous definitions.

Your committee endorses the Joint Statement of Ophthalmologists as submitted by the Section on Ophthalmology of the American Medical Association, the American Academy of Ophthalmology and Otolaryngology, and the American Ophthalmological Society and recommends its acceptance by the House of Delegates.

The revised rules of the Judicial Council, which were submitted for the information of the House of Delegates, were of great interest to your committee. It believes that the publication of the rules in this manner will clarify many of the misunderstandings that have existed between members of the Association and the Judicial Council.

Address of Secretary of Health, Education, and Welfare, Oveta Culp Hobby

The Speaker introduced Mrs. Oveta Culp Hobby, Secretary of the Department of Health, Education, and Welfare of the United States Government, who delivered an address after which the audience arose and applauded. (See Secretary Hobby's address in THE JOURNAL, Dec. 18, 1954, pages 1506-1508.)

Address of Mr. Edwin J. Faulkner

Mr. Edwin J. Faulkner, President, Woodmen Accident and Life Company, Lincoln, Neb., was presented to the House by the Speaker and delivered an address entitled "Why Federal Health Reinsurance Is Not the Answer." (See Mr. Faulkner's address in THE JOURNAL, Dec. 18, 1954, pages 1508-1510.)

Introduction of Representative of American Dental Association

The Speaker introduced Dr. Gerard Casey, Secretary of the Council on Dental Services of the American Dental Association.

Report of Council on Medical Education and Hospitals

Dr. H. G. Weiskotten, Chairman, presented the report of the Council on Medical Education and Hospitals (see THE JOURNAL, Nov. 6, 1954, pages 975-981), which was referred to the Reference Committee on Medical Education and Hospitals.

REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Dr. Walter P. Anderton, Chairman, submitted the following report, which was adopted:

Report of the Council on Medical Education and Hospitals: The annual report of the Council on Medical Education and Hospitals occupies almost six pages of the Nov. 6, 1954, JOURNAL of the American Medical Association. The scope of activities and constructive accomplishments of this Council deserve your admiration and support and fully justify the 1954 budget.

Through your action a year ago, the Trustees referred to this Council the matter of gaining factual information regarding schools of chiropractic and naturopathic schools. This matter has not yet been concluded.

As requested by this House, the Council on Medical Education and Hospitals in its annual report on internships and residencies designated hospitals accredited for intern training.

A large and continuing problem concerning foreign medical school graduates continues to be studied in cooperation with the Advisory Committee on Foreign Medical Credentials, the Committee on Foreign Medical Credentials of the Council on Medical Education and Hospitals, and the Cooperating Committee on Graduates of Foreign Medical Schools.

During the year, the Council has discontinued issuance of the "Essentials of a Registered Hospital" and the "Essentials of an Approved Graduate Medical School" as being no longer necessary.

The 50th Congress on Medical Education and Licensure, Feb. 7-9, 1954, in Chicago, had an attendance of 531. This activity is well worth while.

Thirteen medical schools were visited for consultations or surveys, in liaison with the Association of American Medical Colleges. The Council reports that there are now 74 four-year medical schools in the United States and 11 in Canada.

The Division of Hospitals and Graduate Education has justified its creation, and the Council bespeaks the support of the House of Delegates for the National Intern Matching Program, believing that it has been eminently successful.

The Joint Commission on Accreditation of Hospitals and this Council have maintained close liaison. The field staff of the Council, in addition to reviewing internship and residency programs in many hospitals, has completed a survey of the organizational, administrative, and professional aspects of these institutions in accordance with the program of the Joint Commission on Accreditation of Hospitals. The Council approval of many hospitals and technical schools has been reviewed, with change of status for some.

The Council on Medical Education and Hospitals has 5 standing committees, 5 special committees, 12 residency review committees, and 5 more in preparation. Furthermore, the Council "has active representation and participation" in 10 related activities: Joint Commission on Accreditation of Hospitals; Committee on Financial Needs of the Medical Schools; National Intern Matching Program; Advisory Council and Trustees of the National Fund for Medical Education; American Medical Education Foundation; National Board of Medical Examiners; Federation Bulletin; Medical Technology Study Committee; Selective Service System; Education and Training Division, Surgeon General's Office, Department of the Army.

The Council feels that it should have an assistant secretary for the field of postgraduate medical education and another assistant secretary for the problems connected with foreign medical schools and that there is need of an assistant director for the Division of Hospitals and Graduate Education. In order to accomplish its work, your reference committee recommends that you approve these additions to the staff of the Council.

Your reference committee again registers its appreciation for the many accomplishments for the good of the public and our profession during the past year by the Council on Medical Education and Hospitals.

Report and Supplementary Report of the Council on Medical Service

Dr. Joseph D. McCarthy, Chairman, presented the report of the Council on Medical Service (see THE JOURNAL, Nov. 6, 1954, pages 981-987) and the following supplementary report. The report and the supplementary report were referred to the Reference Committee on Insurance and Medical Service.

SUPPLEMENTARY REPORT OF COUNCIL ON MEDICAL SERVICE

The report of the Council on Medical Service as published in THE JOURNAL and the Handbook of the House of Delegates referred to a supplementary report covering two subjects of interest to the profession. Those subjects are: (1) simplified insurance claim forms; and (2) problem areas in voluntary health insurance as embodied in the resolution introduced by Dr. W. W. Baum, Oregon, and adopted by the House of Delegates during the 1953 Clinical Meeting.

SIMPLIFIED INSURANCE CLAIM FORMS

With respect to simplified insurance claim forms, the Committee on Prepayment Medical and Hospital Service of the Council has conferred with a Special Committee of the Health Insurance Council. This special committee has completed the drafting of two simplified blanks. One has been approved by the Council on Medical Service. The other has been approved in principle, and the Council on Medical Service is suggesting certain modifications. It is planned that the approved form will be publicized to the profession through constituent associations and component societies. Moreover, as soon as further developments take place, it is planned they will be reported to the profession through THE JOURNAL as well as by communication through constituent and component associations and societies.

RESOLUTION ON VOLUNTARY HEALTH INSURANCE

Background: The resolutions introduced by Dr. W. W. Baum, Oregon, called for special studies in the voluntary health insurance field with respect to two groups of citizens, "namely: (a) those persons who suffer catastrophic or long-continued and highly expensive illness and whose financial resources are not adequate to meet the costs thereof, and (b) those citizens who have retired and are living on small incomes and who are not eligible under presently existing public or private plans; . . ." The resolutions further call for a report, including recommendations, to the House at the Miami meeting as well as publication of findings and recommendations to be available not only to the medical profession but to interested nonmedical groups and individuals.

In preparation, contacts have been made with individuals and organizations experienced and interested in these problem areas. These contacts have been in person and by correspondence. During the summer months, a medical student was assigned to the Council and its Committee on Prepayment Medical and Hospital Service. A substantial portion of his available time was devoted to the problems outlined by these resolutions. At this time, it is the opinion of many that any report should be one of a progress or status nature and somewhat devoid of specific recommendations, until such time as more credible experience has been gained. Insurancewise, both of these areas are relatively new. While it is true that a substantial number of insuring organizations have permitted the continuance of previously issued insurance to increasing age levels, it is only recently that the problems of initial issuance of insurance to persons of advanced age has received much study. Likewise, catastrophic, or major hospital and medical expense insurance, is relatively new. The latter is still considered in its experimental stages, and further development may depend on several factors that will be outlined later.

To a degree, many persons may find themselves in both of the problem areas spelled out in the Oregon resolutions: that is, a person may have attained an advanced age and also suffer from a continued illness requiring expensive therapy. It is somewhat axiomatic in insurance that the person who needs it most may be least able to afford it. Moreover, it is impossible to calculate in advance, with any degree of accuracy, which individuals within a given group will suffer a long-term illness necessitating costly treatment.

Insurance for Retired Persons: The problems incident to continuing insurance for retired persons are not for the insuring organizations alone to solve. Blue Shield plans and Blue Cross plans have attempted to make continuing coverage available to persons upon retirement. Private insurance companies in increasing numbers are making extensions available. Aside from the desire of persons to continue protection after retirement, there are at least two problems: (1) the cost of insurance at higher ages; and (2) suitable methods of paying such costs.

Increased costs of insurance at higher age levels are fairly well recognized. The actual amount of increase depends on many factors, including age, sex, and previous health history. Various methods have been proposed to plan in advance for these increased costs, including added surcharges at younger ages to offset the necessary higher charges in later years. This approach presupposes the purchase of insurance during the early years plus the continuance of coverage on a more or less uninterrupted basis. Regardless of how well recognized the increased cost is in many instances, there remains the problem of a suitable mechanism for continuing the premiums on behalf of the retired person to the insuring organizations. In this connection, the most ideal arrangement is where the employer handles the continuing pension payments to the annuitant. The employer who administers a pension program facilitates continuance of health insurance, since it is easier to process the annuitant's contribution and maintain this phase either as an integral part of, or as a supplement to, the program available to active employees. This procedure minimizes the clerical expense of personal accounts.

Several large organizations are experimenting with continued health insurance protection for retired employees. One study of employee benefit plans available to employees of over 250 concerns indicated that of this number only about 25 employer organizations provided specifically for continuing health insurance benefits subsequent to retirement. Some programs apply only to the retired employee, while others include benefits for the spouse. In light of some rather costly arrangements in the fields of pensions and continuation of life insurance, some employers are moving quite cautiously in the realm of health insurance. Apparently the cost to industry of previously made commitments was not calculated correctly. As the number of pensioners increase, additional costs are apparent. In a recent discussion of the increasing numbers of retired persons in the future, a representative of a large midwestern organization made an interesting observation regarding his own company. He indicated that now there was a rate of 35 active employees for each retired annuitant. On the basis of his calculations, sometime within the next 40 to 50 years there would be one retired annuitant for each six active employees. Then, too, many employers are concerned about the extent to which continued contributions for health insurance for retired employees may be a proper charge against operating costs of industry.

Included among the methods of financing those benefit plan programs now being continued to retired persons are: (1) full cost assumed by the former employer; (2) full cost assumed by the annuitant; (3) sharing the cost between the former employer and annuitant; and (4) full cost assumed by a foundation that may have been created by an industry. Since there are relatively few foundations in comparison to the number of employer organizations, this type of financing is perhaps the exception. It is possible that foundations may contribute most to the solution of some of these problems by being encouraged to undertake special studies to determine the approximate cost of these special programs.

In view of the above, it is more readily understandable why some of the initial and current experiments are more or less modest.

Catastrophe Coverage or Major Hospital and Medical Expense Benefits: Starting approximately five years ago, with relatively little precedent, this type of coverage has been extended to an estimated 1.5 million persons. The first experiment was composed of a group considered ideal from an underwriting standpoint. The average age of membership was well below 50, and the mean income was appreciably above average. Initially, benefits were available only to members of the group. After a year, coverage was extended to dependents. Among the basic objectives of this type of insurance are: (1) development of a service to meet a real demand in minimizing financial loss in meeting the expenses incident to health care; (2) making such services available to a large segment of the population; and (3) striving for successful operation consistent with sound underwriting.

During these five years, many accomplishments have taken place and many problems have been brought into clearer focus. After the initial experimentation of only one insurance company, now upwards of 30 private insurance companies and some 12 Blue Shield or Blue Cross plans are offering adaptations of this type of insurance. In a sense, this protection may be more available than this would indicate through the facilities of the two insurance companies owned by the Blue Shield and Blue Cross plans. Some companies prefer to offer this insurance only when they have underwritten the basic program. Other companies prefer to offer this only to those who have no basic program to cover relatively minor losses. Still others will offer it to supplement any initial program provided the initial program is susceptible to clear definition. Thus, differing underwriting attitudes can be readily identified.

Lack of Safeguards: Unlike life insurance and various aspects of property insurance, this class of coverage does not yet enjoy some of the well-established guideposts. Among the problems are: (1) lack of definition as to what constitutes a catastrophe; (2) lack of identification of "usual" costs incident to health care; (3) duplication of benefits; and (4) the extent to which the fact that a person is insured may influence a loss. (N. B. This problem is separate from the one wherein a professional charge may be amended when the existence of insurance becomes known.)

With the lack of some of the normal restraints and in the hope of offering protection containing a minimum of limitations or exclusions, many underwriters attempt to utilize what might be called controls. These are often accomplished by either or both the principle of deductible insurance and the feature of coinsurance. The former is an assumption of all small losses (up to a predetermined amount) by the insured, while in the latter the insured maintains a continuing financial interest (usually a specified percentage) in all costs assumed. Some authorities have preference for one or the other, but a majority seem to recognize the need for both at this time.

Geographic Variations in Health Care Costs: Another problem in attempting to market this newer type of insurance program on a nationwide basis is the variation of costs for health services reflected in different geographic areas. In a study undertaken by one large insurance company, it was found that if the net costs were $3.00 per month per claim countrywide, the costs on a rough geographic area basis would be: East, $3.00; Midwest, $2.50; South, $2.00; and West, $4.00. To a large extent, these variations may parallel similar economic differentials in these areas. The initial pricing due to location at the inception of a risk may not be a final solution due to the mobility of our population. Conceivably, a person may buy his insurance in a low cost area but seek health care in a high cost area.

Other Cost Factors and Variables: Other studies conducted by the same organization showed that such items as income of the insured, composition of the family group, and age play a decided part in determining costs. The results indicated that medical care expenses of persons earning $10,000 to $15,000 per year were twice the expenses of those earning from $5,000 to $7,500. In this regard, differences were reportedly much more noticeable in fees for surgery and special nursing than were the differences in charges for hospitalization.

In the study of the effect of age on claim costs the age groups used were as follows: (1) under 35; (2) 35-50; (3) 50-65; and (4) age 65. Net claim costs averaged twice as much in the grouping 35 to 50 than for those under age 35. The age group 50 to 65 developed claim costs of five times those under age 35. At age 65 itself, the claim cost was 10 times as much as it was for those under age 35. (N. B. While these factors were developed in a study involving claim costs under "catastrophe coverage," they may have significance with respect to any type of health insurance costs.)

Unusual Claims: Although this type of insurance is new, the vagaries of human imagination often become apparent when one considers certain items that have been billed for under this form of coverage. Spiritous liquors (in case lots) have been listed as charges when an attending physician may have recommended a slackened pace or an occasional libation at the end of a day and prior to dinner. Vacation travel has been used as a basis for claims when a physician may have advised a brief respite from business tensions. The most recent instance to come to attention was a request to pay the salary of a companion for a child who was experiencing some personality difficulties. Other examples could be mentioned but the above are sufficient to indicate some of the administrative problems.

The Future of Major Expense Benefits: The sections of the Council report entitled "Major Hospital and Medical Expense Insurance" and "Insurance Abuses" contain material worthy of your attention in connection with this special report. Rather than restate it here, it is commended for your further review. According to some authorities, the future of this class of coverage may be influenced by many elements such as: (A) abnormal charges for surgical procedures to patients in above-average income groups; (B) the degree to which this coverage is extended to average and modest income groups; (C) the degree of employer contribution toward premium costs coupled with the extent to which such contributions are considered proper charges against operating costs; and (D) the extent to which insured persons and the health professions want minor cost items included in the benefit structure so as to distort the true function of insurance, which is to minimize financial loss rather than eliminate it entirely.

The attitude of spokesmen for labor groups concerning this phase of voluntary coverages may also be a factor to be considered in further development. While some spokesmen are enthusiastic about the maximum amounts of benefits, a few have indicated a dislike for the features of deductible insurance and coinsurance.

Conclusions and Recommendations: In view of the foregoing and in light of the attention now being devoted to these problems by the industry of insurance as well as industry in general, it is recommended that these special studies be continued and intensified. Liaison has been established with several industries considering both the problems of catastrophe benefits and continuing coverage after retirement, as well as with many of those employers who have made partial progress toward solving these problems.

Liaison has been maintained also with the insurance industry, but this could be intensified, especially in those instances where problems of insurance involve the health professions. It is interesting to note that the Group Committee of the Bureau of Accident and Health Underwriters is making a study of group coverage on retired employees. Perhaps the Committee on Prepayment Medical and Hospital Service of the Council should see to what extent its continuing efforts could be correlated with this and other similar studies so as to minimize unnecessary duplication of effort. As further information is obtained through intensified studies, it is possible that methods of financing other than insurance may have to be explored in these problem areas. This may be especially true in those instances where the additional costs of insurance for higher age groups have not been funded properly prior to the attainment of retirement age.

It is recommended that the Council maintain its interest in these problems and continue studies in cooperation with others. It is further recommended that as specific information is developed it be submitted to THE JOURNAL for publication, and

finally that the Council on Medical Service offer continuing liaison with employer groups, insurance organizations, and others through its Committee on Prepayment Medical and Hospital Service in helping solve any problems that may involve the health professions.

In closing, the Council wishes to pay tribute to all of the members of its several committees who have devoted their time and efforts in considering the many problems that are of concern to the Council on Medical Service and to the medical profession.

REPORT OF REFERENCE COMMITTEE ON INSURANCE AND MEDICAL SERVICE

Dr. William M. Skipp, Chairman, submitted the following report, which was adopted:

Hospitals and the Practice of Medicine: This controversy has levelled off in many sections of the country where it was a hot issue, but there still are areas where there is bickering. The House of Delegates has set up a yardstick in accepting committee reports of December, 1951, and June, 1953, wherein the practice was defined in hospitals.

Physicians' Placement Service: This service has experienced a great response in its attempt to learn through regional conferences, field studies, and thousands of articles in national, state, and local publications, what the real need is for better distribution of physicians over the entire country. The placement operations have been taken up by most of the state medical organizations, and hundreds of physicians have been placed in needed areas. The requests have increased from physicians, and at present there are more physicians looking for locations than there are places to be filled. The general practitioners' requests head the list. In the last year fee schedules have been set up and studied for an average fee, and a loan kit on this subject has been made available.

The Hill-Burton Act has helped a great deal in the construction of hospitals, particularly in the areas where no hospitals existed before (59% are in communities of less than 5,000). Now, with new grants on the 1954 amendment, emphasis has been placed on diagnostic or treatment centers, chronic disease, rehabilitation, and nursing homes.

The Indigent Medical Care Committee has worked in the field, both with local, state, and national organizations, always keeping in mind that there should be reasonable payment to physicians on a basis agreed to by the local medical society, and that free choice of physicians wherever feasible in home or office be maintained. This committee urges the House of Delegates to make a special plea to medical societies to familiarize themselves with the need in their communities and to cooperate with other organizations in assuring that the indigent and medically indigent have needed medical, hospital, and other related services made available to them.

The Committee on Child Care has interested itself in conjunction with other national organizations interested in this problem. A study program has been set up to get the best information, with conferences, articles in publications of note, making available brochures on these articles, then field conferences where needed. These are important in this field, in which the committee is trying to develop leadership.

Medical care for military dependents has been given a thorough study. The Council urges the House to refresh itself on the activities of the study and report of the Los Angeles County Medical Association on this project, found in THE JOURNAL of the American Medical Association for June 7, 1952; June 20, 1953; and Sept. 5, 1953. The House of Delegates adopted the following statement relative to these two recommendations: "In regard to the request that the Los Angeles County Medical Association carry out the requests of the Council in the matter of a pilot study in maternal and child care, and that the conclusion of this study be recommended to all county medical societies, your reference committee has taken no action, inasmuch as it understands the study is at present stalled for lack of funds." The Council and its Committee on Maternal and Child Care believe there must have been some misunderstanding. In the first place, the Committee's studies in Los Angeles were completed and published, and are not "stalled for lack of funds." Secondly, specific recommendations had been made that, if followed, would have demonstrated that servicemen's dependents can be cared for in most local areas without federal programs. Thirdly, these recommendations were and are applicable to many other areas and could well have been commended to other medical societies for study.

Medical Care for Industrial Workers—Management-Sponsored and Union-Sponsored Health Centers: The old centers with new ones are being visited. The Committee is much concerned with rules and regulations of these clinics. It would establish basic principles of operations and the relations of physicians to the operation, so that medical societies would have a starting point for evaluating plans in operation or being proposed in their area.

United Mine Workers: The Committee on Medical Care for Industrial Workers has done considerable work relative to improving medical care in these areas. Dr. Warren F. Draper, executive medical officer of the United Mine Workers of America, says he has received a great deal of help from this Committee and the American Medical Association, and that through its committees he has received invaluable assistance.

Prepayment Medical and Hospital Service: We all know of the growth of these insurance services and that they are still increasing under the supervision of rules and regulations set up by this Committee. A new form of major hospital and medical expense insurance is being proposed, referred to as catastrophe coverage. The number of persons covered had rapidly increased within the last year. The growth of this type of insurance depends on the insured and health professions. The benefits are not geared to schedules but to rather generous maximum policy limits. The policy will pay "usual charges" for professional services that are deemed reasonable in the area where the service is rendered.

Privileges granted to the profession can be abused and will deplete the fund, because the premium must be fixed. There is no reason, because of this type of insurance, that fees should be raised, because with increased cost the insurance is taken out of the buyers' reach.

Insurance Abuses: The Committee on Prepayment Medical and Hospital Service was formed to deal with voluntary health insurance. It has found that there are many other things that have to be studied in life, health, and accident plans. One of the things the Committee has found is the extent to which some physicians have allowed themselves to be used in personal injury claims of questionable merit. The claims may be false, and the physician has been drawn in without his due knowledge of the truth, or the physician may have conspired with the claimant and others to defraud. This is of interest to the whole profession because of the reflection on the whole. The Committee feels it should continue in this field unless the House of Delegates indicates otherwise.

Simplified Insurance Claim Forms: A special committee has devoted a good deal of time to this problem. This has taken and still will take much time, because of the diversity of types of insurance and the large number of companies in the field. Four hundred companies were contacted for the purpose of determining what is a minimum requirement. This information has been compiled, and in the near future the medical profession representatives will be contacted to get a report of progress to date. The reason this was not set into form several years ago is that several state and local societies said they were setting up their own forms, which never came to pass. Several of the companies could not see why a form approved by the Council on Medical Service should be accepted if the whole profession was not going to use it. This special committee has completed the drafting of two simplified blanks. One has been approved by the Council on Medical Service. The other has been approved in principle, and the Council on Medical Service is suggesting certain modifications and encouraging further efforts. It is planned that the approved form will be publicized to the profession through constituent associations and component societies. This report should be read by every member of the House of Delegates, as it is certainly enlightening and will give a great deal of help to these problems.

Report of Council on Constitution and Bylaws

Dr. Louis A. Buie, Chairman, read the following report of the Council on Constitution and Bylaws, section 1 of which, containing an amendment to the Constitution that had been held over from the San Francisco Meeting in June, was adopted without referral. The remainder of the report of the Council was referred to the Reference Committee on Miscellaneous Business.

Since the meetings of the House of Delegates in San Francisco in June, 1954, three matters have been referred to the Council on Constitution and Bylaws. One pertains to the Constitution, one to the Principles of Medical Ethics, and one to resolution no. 47 from the June, 1954, meeting.

1. During the San Francisco meeting of the House of Delegates in June, 1954, a plan was presented for the reorganization of the Council on Scientific Assembly. Certain changes in the Constitution and Bylaws of the Association were required in order to implement this reorganization plan. The necessary changes in the Bylaws were recommended by this Council and approved by the House of Delegates at that time. It was necessary, however, for consideration of the constitutional changes to be deferred until this meeting. Therefore, the Council on Constitution and Bylaws now recommends that Article IX, Section 3 of the Constitution be amended by deleting the words "Council on Scientific Assembly" from line three and by substituting therefore the words "Board of Trustees"; and also by deleting the word "Council" from line four and by substituting therefor the word "Board."

2. In its report to the House of Delegates last June the Council on Constitution and Bylaws recommended certain changes in the Principles of Medical Ethics. All of these recommendations were adopted with the exception of one pertaining to section 7 of chapter I, entitled "Patents and Copyrights." At the request of the Chairman of the Council on Constitution and Bylaws the Reference Committee on Amendments to the Constitution and Bylaws referred this section back to the Council for further consideration. An exhaustive study has been made of the problem of patents and copyrights, and the members of this Council have reached several conclusions. They believe that, in and of itself, the act of obtaining a patent or a copyright is not unethical. Physicians for more than a century have obtained copyrights on books they have written, and have been entirely untouched by accusations of cupidity, greed, or restraint of the benefits of research or invention. In fact the copyright in such instances often assures the integrity of the valuable information thus disseminated to the public and protects it from becoming distorted or exploited. However, when a copyright or a patent operates in such a manner as to withhold or retard the benefits of an invention from the very patients whose ills it is designed to alleviate, then the owner of that patent or copyright clearly is in a position at variance with ethical conduct.

Excessive royalties from the products of an invention are regarded with disfavor, because they may tend to stifle research and limit the dissemination of its uses and its benefits. Considerations of humanitarian import must not suffer in the interests of financial reward. Scientific and medical educational institutions should be permitted to own patents and copyrights and receive royalties from them without exposure to invidious criticism, because the monies thus involved accrue to the benefit of the public in the form of the enhancement of medical education and research and in the stimulation of charitable works.

The Council therefore recommends the following substitute for chapter I, section 7, of the Principles of Medical Ethics and requests its consideration by the House of Delegates:

> A physician may patent surgical instruments, appliances, and medicines or copyright publications, methods, and procedures. The use of such patents or copyrights or the receipt of remuneration from them which retards or inhibits research or restricts the benefits derivable therefrom is unethical.

3. Resolution no. 47 from the June, 1954, meeting, introduced by Dr. George A. Unfug, Colorado, was referred by the House of Delegates to the Council on Constitution and Bylaws by recommendation of the Reference Committee on Constitution and Bylaws. This is the resolution under consideration now. Since, however, resolution no. 47 is virtually identical in both content and intent to two other resolutions on which action already has been taken, the dictates of sound parliamentary procedure will be best served, first, by examination of the broad, general subject embodied in all three resolutions from the time that subject was first advanced, and second, to ascertain what has happened to that broad, general subject which would require it to be expressed in three separate resolutions.

The first time the same broad, general subject embraced in all three resolutions was submitted to the consideration of this House of Delegates was in December, 1953, in the form of resolution no. 19. An analysis of this resolution by the Council on Constitution and Bylaws was presented to the House of Delegates in June, 1954, and the House voiced disapproval of resolution no. 19 by unanimous vote. That disposed of the December, 1953, resolution.

Resolution no. 35 was introduced by Dr. Paul D. Foster, California, in June, 1954. This resolution, almost entirely identical to resolution no. 47, was referred to the House of Delegates by the Reference Committee on Amendments to the Constitution and Bylaws with an adverse report. The House of Delegates similarly recorded its disapproval of this resolution. That disposed of resolution no. 35 introduced in June, 1954. There remains, however, resolution no. 47, which is almost identical to resolution no. 35.

Resolution no. 47 was introduced in June, 1954. It is this resolution on which action is to be taken. It is the only resolution remaining among the three resolutions whose purpose is virtually the same.

Intent of Resolutions: What is the broad general objective embodied in all three of these resolutions?

A. The objective is to amend the Bylaws in such a manner as to require the Judicial Council to report to the House of Delegates, at each session, all interpretations of the Principles of Medical Ethics and all interpretations of the policies of the American Medical Association for examination by the House of Delegates.

B. Secondary to the main objective as stated above, resolution no. 47, like resolutions no. 19 and 35, prays that when an investigating jury is not requested in a given case, the Judicial Council be required to give each party concerned a hearing in the presence of the other; that each party be notified beforehand of the meeting which is to deal with his case; that no opinion by the Judicial Council be rendered until at least 60 days after request for such an opinion has been published in THE JOURNAL of the American Medical Association in two consecutive issues; and that any member of the American Medical Association or his representative may present his views in writing on a given matter to the Judicial Council, or that if a constituent or component medical society so wishes, it may request a hearing in a given matter at which a representative of such a society may present the views of that society.

Analysis: Here there are only three main matters to be considered: (1) Resolution no. 19, the progenitor of the other two resolutions, has been rejected by the House of Delegates. (2) Resolution no. 35, which is virtually identical to resolution no. 47, has been rejected by the House of Delegates. (3) Resolution no. 47, which is in effect a creature of resolutions no. 19 and 35, can hardly escape the same destiny accorded the previous two resolutions.

Never in any community where the course of justice has been unfettered has the judicial function been confused with the legislative function, nor can the consummation of justice and equity be achieved by the subordination of judicial procedure to the expediencies of the legislative process. No mechanism for the assurance of justice among men can long escape disaster if it is exposed to derangement by those who are charged with the drafting of measures exacted by contingencies in which the judicial process actually has little to do.

All these resolutions—no. 47, under consideration now, as well as the preceding ones—cannot be put into action without perverting the ancient and inviolable doctrine of separation of the judicial from the legislative in the democratic scene. Because these resolutions embody a principle that is offensive to reason, destructive to justice, and repugnant to sound parliamentary

practice, they have been rejected in an act of wisdom by the House of Delegates. Resolution no. 47 should be accorded the same summary disposition. In fact, should the remote contingency arise in which resolution no. 47 might gain acceptance, the action of the House of Delegates in rejecting resolution no. 35 in June, 1954, would have to be rescinded, for both resolutions are cut from the same fabric of indifference to both reason and justice.

Finally, the proposed resolution, like its predecessors, falls without hope of defense, because any member of the House of Delegates, by express stipulation of the Bylaws, has the privilege of reviewing the detailed work of the Judicial Council on his own time, and if he wishes to acquaint himself with any matter of interest to himself in the orderly procedures of the Judicial Council, he will encounter no barrier to his wish. Justice and reason were well served when resolutions 19 and 35 were rejected. The Council on Constitution and Bylaws recommends that the House of Delegates take the same action and voice its disapproval in respect to resolution no. 47.

REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

Dr. Frank J. Elias, Chairman, presented the following report, which was adopted:

Report of Council on Constitution and Bylaws, Section 2: Your reference committee approves the recommendation of the Council on Constitution and Bylaws found in Section 2 of its report, that section 7 of chapter I of the Principles of Medical Ethics be amended to read as follows:

> A physician may patent surgical instruments, appliances, and medicines or copyright publications, methods, and procedures. The use of such patents or copyrights or the receipt of remuneration from them which retards or inhibits research or restricts the benefits derivable therefrom is unethical.

Section 3: Your reference committee concurs with the Council on Constitution and Bylaws that justice and reason were well served when resolutions no. 19 introduced during the December, 1953, meeting and no. 35 introduced during the June 1954, meeting of the House of Delegates were rejected. Your committee recommends that the House of Delegates take the same action now and voice its disapproval of resolution no. 47 introduced during the same session.

Progress Report of Special Committee on General Practice Prior to Specialization

Dr. A. C. Scott Jr., Chairman, submitted the following progress report of the Special Committee on General Practice Prior to Specialization, which was referred to the Reference Committee on Medical Education and Hospitals:

The Special Committee of the House of Delegates on General Practice Prior to Specialization has met three times in 1954. In its initial meetings in 1953, the Committee formulated a working plan and policies in an endeavor to accomplish the objectives and purposes for which it was created by this House.

These objectives were briefly: (1) a broadened base of education in the art of medical practice for all doctors entering specialized practice; and (2) a better distribution of doctors between urban and rural areas.

With respect to the first objective: It is based on the concept that some experience in general practice will tend to decrease the present trend toward sheer scientific specialization and place more emphasis on the humanics and fundamental humanitarianism of the art of medicine to the end that all-around better specialists will be produced and the public better served. The second objective is based on the concept that a required short period of training in general practice experience would automatically create a better distribution of doctors between urban and rural areas, a condition the public is begging for and the government more or less demanding. It is believed by many that the attempted accomplishment of these two objectives would create much better public relations between the public and the medical profession.

The Committee first made a study of the various requirements of the 19 specialty boards. It then sets out to determine from certified specialists in the various specialties their beliefs concerning the value of general practice experience to a doctor in their respective specialties.

A postcard questionnaire containing only five questions was sent to all certified specialists last spring in three cities of average size in the East, Midwest, and Southwest. The cities selected were Hartford, Conn.; Toledo, Ohio; and Albuquerque, N. Mex. Replies were received from 74% of the 426 specialists sent questionnaires.

In category A, that is, those certified specialists who had had general practice experience prior to certification, 92% believed that it was valuable to them in the practice of their specialty and recommended two to three years general practice experience for all prospective specialists. In category B, those certified specialists who had not had general practice experience, more than 40% believed that it would have been valuable to them and recommended that prospective specialists have one to two years general practice experience prior to specialization.

In July of this year, the Committee, with the assistance of the Bureau of Medical Economic Research, sent an almost identical questionnaire to 9,600 American board diplomates all over the United States. These specialists were selected at random from IBM records. They comprised 25% of all specialists in the IBM main file, most of whom were certified prior to 1951. Replies were received from 6,400 of the 9,600 diplomates to whom questionnaires were sent. The Bureau of Medical Economic Research tabulated the replies for the Committee and prepared a series of breakdowns according to specialty, year of certification, age, state and region, size of city, year of graduation from medical school, etc. More than 90% of those in category A, those who reported some general practice prior to specialization, approved the idea and recommended such experience for future specialists. In category B, those diplomates who had not had general practice experience, 38% approved it for future specialists. In general, the results of this questionnaire agreed with the earlier small sample of three cities.

The Committee is now preparing another small sampling questionnaire to be sent to 10% of the 6,400 diplomates who answered the last one to elucidate the reasoning back of their replies. This study should be completed within two to three months.

The Committee considers these preliminary questionnaires and studies essential to any attempt to implement the objectives set out in the original resolutions of the House. Until all of the studies of these questionnaires have been completed, and until the Committee has had an opportunity to discuss the results of these studies with the Council on Medical Education and Hospitals, and the governing bodies of various specialty boards, it deems it unwise to formulate conclusions or recommendations. Therefore, the Committee has no recommendations to make at this time. It will give to the House at the June, 1955, session the detailed results of the surveys, and hopes to be prepared to make recommendations at that time.

REPORT OF REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Dr. Walter P. Anderton, Chairman, presented the following report, which was adopted:

Progress Report of Special Committee on General Practice Prior to Specialization: Your reference committee has considered the progress report of the Special Committee on General Practice Prior to Specialization, which, as its title indicates, is merely a report of progress. The Committee is to be commended for the study that has been made and its recognition of the fact that there were two definite objectives which were kept in mind. These objectives were a broadened base of education in the art of medical practice for all doctors entering specialized practice, and a better distribution of doctors between urban and rural areas. The study has not been completed and the special committee plans to make a further report to the House of Delegates at the June, 1955, session. Your reference committee recommends that the progress report be accepted.

(Concluded in next issue.)

MEDICAL NEWS

ARIZONA

Physician Honored at County Fair.—The Yavapai Fair Association designated Sept. 18 as "Doctor Looney Day" in honor of Dr. Robert Nelson Looney, Prescott, charter member of the 50-year-old Yavapai Medical Society, and oldest member of the Arizona state association residing in the state. Dr. Looney came to the mining town of McCabe in the Arizona Territory in 1896 and built a small hospital. He was the first state health officer (1912-1917), Yavapai County physician for more than 30 years, and surgeon to the Santa Fe Railroad for 50 years and served in the territorial legislature in 1905-1906. In 1913, realizing that the elk had been almost exterminated in Arizona, Dr. Looney began a campaign to restock the forests and personally underwrote the expense of bringing the first herd down from Yellowstone Park.

ARKANSAS

Dr. Rodgers Joins University Faculty.—Dr. Terry C. Rodgers, formerly of New York, has been appointed associate clinical professor of psychiatry of the University of Arkansas School of Medicine, Little Rock, and consultant to the Veterans Administration Hospital, North Little Rock, and the State Hospital, Little Rock.

Society News.—The Arkansas Obstetrical and Gynecological Society met in Little Rock, Oct. 22 and 23, with the Memphis and Mississippi societies as guests. There were 75 in attendance. Dr. Jason H. Collins, assistant professor of obstetrics and gynecology, Tulane University of Louisiana School of Medicine, New Orleans, discussed "Use of Tracheotomy in Eclampsia" and "Cul-de-Centesis as an Aid in Gynecology"; Dr. James R. Reinberger, professor of obstetrics and gynecology, University of Tennessee College of Medicine, Memphis, "Hysterectomies in Memphis Private Hospitals"; and Dr. Harold Feinstein, instructor in obstetrics and gynecology, University of Tennessee College of Medicine, Memphis, "Functional Uterine Bleeding." The remainder of the program was presented by members of the Arkansas society and residents from the University of Arkansas School of Medicine, Little Rock, and Tulane University.

CALIFORNIA

Society News.—At the annual meeting of the California Society of Internal Medicine in Yosemite National Park, Oct. 2, the principal speaker was Dr. Harry F. Dowling, professor of medicine, University of Illinois College of Medicine, who discussed "The Clinical Significance of Antibiotic-Resistant Bacteria." A panel discussion on antibiotics was moderated by Dr. Lowell A. Rantz of San Francisco. Members of the panel were Dr. Ernest Jawetz of San Francisco and Dr. Harold E. Pearson of Los Angeles. The following officers were elected for 1954-1955: Dr. Paul I. Hoagland, Pasadena, president; Dr. George K. Wever, Stockton, vice-president; and Dr. James H. Thompson, San Francisco, secretary-treasurer.

Muscular Dystrophy Clinic.—Applications are being accepted for admittance to the new Muscular Dystrophy Clinic in Los Angeles, which opened Nov. 10. Patients interested in enrolling for the clinic's specialized services may apply by calling the Muscular Dystrophy Association office at DUnkirk 5-1355 or the Good Hope Clinic, MIchigan 3981 (1241 Shatto St.), where the Muscular Dystrophy Center functions under the supervision of the University of Southern California School of Medicine, with Dr. Elizabeth S. Austin, U. S. C. faculty member and director of physical medicine and rehabilitation at Los Angeles County Hospital, as clinic director. According to Dr. Austin, patients admitted will be given a complete medical examination and social service interview, in keeping with the clinic's aim to render total patient care and family guidance. Orthopedic appliances will be prescribed, physical therapy will be given, and psychiatric assistance will be provided for patient and family.

Personal.—Dr. Robert Wartenberg, San Francisco, has returned from Freiburg im Breisgau, Germany, where he was guest professor at the university. He lectured also in Frankfurt, Germany; Vienna, Austria; and Belgrade and Sarajevo, Yugoslavia. He read a paper before the German Society for Neurology in Würzburg and, at the meeting of the German Society of Neurosurgery in Bad Ischl, was presented with a diploma of honorary membership.——Dr. Lenor S. Goerke has resigned after eight years as director of district services of the City of Los Angeles Health Department to accept an appointment as professor of preventive medicine and public health at University of California at Los Angeles School of Medicine. Previously Dr. Goerke had served as the health officer of Clatsop County in Oregon and of Yolo County, as director of selective service for Los Angeles during the early part of World War II, and later, after front-line duty, as lieutenant colonel in the Army surgeon's office in Berlin.

COLORADO

State Medical Election.—Newly elected officers of the Colorado State Medical Society include Dr. Samuel P. Newman, Denver, president; Dr. Robert T. Porter, Greeley, president-elect; Dr. Kenneth D. A. Allen, Denver, vice-president; Dr. William C. Service, Colorado Springs, treasurer; and Dr. James M. Perkins, Denver, constitutional secretary.

Course in Medical Technology.—The University of Colorado Medical Center and the Colorado State Society of Medical Technology will sponsor a postgraduate course in medical technology at the center, 4200 E. 9th Ave., Denver, March 16 to 19, 1955. Registration fee is $12.50 for the entire course; $6 for a single day. The principal guest speakers will be Dr. Thomas Hale Ham, Western Reserve University School of Medicine, Cleveland, and Dr. Mervin H. Grossman, director of laboratories, St. Paul's Hospital, Dallas, Texas. Information may be had from the Office of Graduate and Postgraduate Medical Education, 4200 E. 9th Ave., Denver 20.

CONNECTICUT

Physicians Donate Their Fees.—Physicians who treated the 37 injured passengers and crew members of the Air France plane crash in Preston City Aug. 3 have pooled all fees for their services in a fund for purchase of hospital equipment. The action was taken at a recent meeting of the medical staff of the William W. Backus Hospital in Norwich, where victims of the plane disaster were taken.

University News.—Dr. Charles O. Bechtol, formerly assistant clinical professor of orthopedic surgery at the University of California Medical School in San Francisco, has joined the faculty of the Yale University School of Medicine, New Haven, as associate professor of orthopedic surgery. He will also be orthopedist-in-chief of the Grace-New Haven Community Hospital University Service. Dr. Bechtol has been affiliated with the Stanford University Hospitals in San Francisco, the Samuel Merritt and Highland-Alameda County hospitals of Oakland, Calif., and State of Wisconsin General Hospital in Madison.

DISTRICT OF COLUMBIA

Grant for Cancer Study.—A grant of $12,573 to George Washington University School of Medicine, Washington, D. C., from the U. S. Public Health Service will be used to investigate the possibility that the bacteria associated with certain types of ulcerative cancers may contribute to the spread of those cancers within the body. Dr. Calvin T. Klopp, director of the Cancer Clinic, and Angus M. Griffin, Ph.D., professor of bacteriology, will direct the research.

Physicians are invited to send to this department items of news of general interest, for example, those relating to society activities, new hospitals, education, and public health. Programs should be received at least three weeks before the date of meeting.

Tufts College Memorial Gift.—Twelve plaques, each bearing the sculptured portrait of a pioneer in medicine, were presented Oct. 28 to the Armed Forces Institute of Pathology, Washington, D. C., as a memorial to the graduates of Tufts College Medical School, Boston, who died in wartime service to their country. Rear Admiral Bartholomew W. Hogan, deputy surgeon general of the Navy and a graduate of Tufts, spoke for the members of the Tufts Medical Alumni Association at the presentation ceremony. The 12 pioneers (not all of them physicians), listed chronologically, are Imhotep, Hippocrates, Galen, Maimonides, Vesalius, Paré, Harvey, Pasteur, Lister, Roentgen, Osler, and Freud.

FLORIDA

Award to Dr. Ayre.—The Wien award for outstanding research in cancer cytology was presented to Dr. J. Ernest Ayre, director of the Cancer Institute at Miami, by Dr. H. Hudnall Ware of Richmond, Va., president of the Southern Society of Cancer Cytology, at the annual meeting in St. Louis, Nov. 8, held jointly with the Southern Medical Association. The award consists of $1,000 and an engraved plaque given by Mr. Leonard A. Wien, former president of the institute. Dr. Ayre, who is secretary of the Southern Society of Cancer Cytology, was formerly affiliated with the Royal Victoria Hospital in Montreal and served as lecturer in gynecology and director of the cytology research laboratories at McGill University; as director of the Red Cross Blood Donor Clinics in Montreal; as consultant, cytology center, department of pathology, St. Louis University School of Medicine; and as consultant to the Bob Seibels Jr., M.D., Memorial Laboratory in Columbia, S. C. In 1952 Dr. Ayre became a citizen of the United States by a special act of Congress. He has written a textbook, "Cancer Cytology of the Uterus," and an "Atlas of Cervical Cytology."

IOWA

Bierring Award Established.—At the meeting of its board of directors Oct. 14, the Iowa Tuberculosis and Health Association established an award in the name of Dr. Walter L. Bierring, Des Moines, a charter member and in 1917 president of the association. The award will be given to a person who has contributed to the control of tuberculosis or chest diseases in Iowa.

LOUISIANA

Genetics Counseling Service.—A counseling service in human genetics has been established in the Tulane University of Louisiana School of Medicine, New Orleans, to provide persons in the New Orleans area with information on the heredity problems in their families. H. Warner Kloepfer, Ph.D., associate professor of anatomy, will serve as director, in association with Dr. Harold V. Cummins, professor and chairman of the department of anatomy, who was recently elected vice-president of the American Society of Human Genetics. Counseling services will be available to physicians, hospitals, and clinics whose patients have problems directly related to the heredity of one or more members of their families.

MASSACHUSETTS

Dr. Alton Pope Retires.—Dr. Alton S. Pope, Boston, has retired from the Massachusetts Department of Public Health after almost 25 years of public service. Dr. Pope joined the department in 1929 as director of the division of tuberculosis and in 1937 became deputy commissioner of the Massachusetts Department of Public Health, a post that he held until his retirement last summer and filled in addition to his work in tuberculosis.

Course on Pulmonary Function.—Under the sponsorship of the American Trudeau Society and in cooperation with the medical schools of Boston, the fifth annual course, "The Measurement of Pulmonary Function in Health and Disease," will be given at the Boston City Hospital, March 21 to 25, 1955. Information may be obtained by writing directly to the chairman for the course, Dr. Edward J. Welch, 1101 Beacon St., Brookline.

Public Health Scholarships.—The Harvard University School of Public Health, Boston, announces that public health scholarships for the academic year 1955-1956 will be granted to persons of high professional promise in awards ranging from part tuition to tuition plus a stipend, according to the qualifications and financial needs of the applicants. The scholarship funds are primarily intended for citizens of the United States. Scholarship applicants must be eligible for admission to the school as a candidate for one of the following degrees: master of public health, doctor of public health, master of science in hygiene, doctor of science in hygiene, or master of industrial health. A catalogue of the school, admission and scholarship applications, and further information may be obtained by writing to the Secretary, Harvard School of Public Health, 55 Shattuck St., Boston 15. Scholarship applicants must return completed admission and scholarship applications to the Harvard School of Public Health by March 1. Scholarship awards will be announced by May 1.

NEW JERSEY

Society News.—Newly elected officers of the New Jersey Orthopaedic Society include Dr. John J. Flanagan, Newark, president; Dr. William Kruger, Newark, president-elect; Dr. Arthur S. Thurm, Trenton, secretary; and Dr. Harold T. Hansen, South Orange, treasurer.

Personal.—Dr. Ralph F. Schneider, since 1948 assistant medical director of the Standard Oil Company (New Jersey), has been named medical director to succeed Dr. Robert Collier Page, who was made chief medical consultant. Dr. Schneider is assistant clinical professor of industrial medicine at New York University College of Medicine and is on the medical staff of the University Hospital. Dr. Page is associate professor of preventive medicine at New York University School of Medicine, president of the Industrial Medical Association, and chairman of the board of trustees of the Occupational Health Institute, New York.

Physiological Aspects of Parasitism.—The 11th annual Conference on Protein Metabolism, "Some Physiological Aspects and Consequences of Parasitism," sponsored by the Bureau of Biological Research of Rutgers, State University of New Jersey, will be held in New Brunswick, Jan. 28 and 29, 1955. Reports will be given on cultivation of intracellular parasites, intestinal physiology and the host-parasite relationship, protein metabolism of intracellular parasites, glycolytic enzymes of schistosomes, antibody formation, and leishmaniasis and metabolism of the host. The conference is open to all registrants. Reservation blanks may be secured from William H. Cole, Ph.D., Rutgers University, New Brunswick.

NEW YORK

Lecture on Cerebral Palsy.—The gynecologic and pediatric services of the Jewish Chronic Disease Hospital (86 E. 49th St., Brooklyn) will present "Etiology of Cerebral Palsy" by Dr. Nicholson J. Eastman, professor of obstetrics, Johns Hopkins University School of Medicine and obstetrician in chief, Johns Hopkins Hospital, Baltimore, at 8:30 p. m., Jan. 5, 1955, in the auditorium, Freeman Pavilion.

Hospital News.—Hillside Hospital, Glen Oaks, announces the establishment of a research service devoted to the study of psychological, neurophysiological, and biochemical aspects of mental illness. Dr. Maximilian Fink of Great Neck, who served as supervising psychiatrist at the hospital, has been appointed director of research.——Dr. Louis D. Goldberg was recently elected chief of staff of St. Francis Hospital, Poughkeepsie; Dr. Francis A. Gagan was chosen vice-president and Dr. Benjamin A. Perrino, secretary.

Emeritus Professors Named.—Dr. Jean Redman Oliver and Arnold H. Eggerth, Ph.D., who were retired from the faculty of the State University of New York College of Medicine at New York City, in Brooklyn, Sept. 1, have been named distinguished service professor emeritus of pathology and professor emeritus of microbiology, respectively. Drs. Oliver and Eggerth came to the college when it was still the medical college of the Long Island College Hospital. Dr. Oliver, who in 1953 was appointed the first distinguished service professor in the state

university, in 1939 published his "Architecture of the Kidney in Chronic Bright's Disease." In 1953 he received the Borden award for "outstanding research in medicine" at the convention of the Association of American Medical Colleges. Dr. Eggerth has the longest record of service on the college faculty (35 years). Although retired from the faculty, he will continue in active association with the college, assisting Dr. Jean A. Curran, recently appointed professor of the history of medicine, in the organization of a new department of historical and cultural medicine.

New York City

William Henry Welch Lecture.—The 23rd William Henry Welch lecture was delivered at Mount Sinai Hospital of New York, Dec. 2, by Mr. P. R. Allison, F.R.C.S., Nuffield professor of surgery, Oxford University, England, who discussed "Hiatus Hernia of the Diaphragm: Its Pathogenesis and the Anatomy of Repair."

Fellowships in Psychiatry.—The Mount Sinai Hospital offers a program for training in child psychiatry. The team approach with psychiatric case work, psychology, and pediatrics, as well as a psychodynamic psychoanalytic orientation, is stressed. An honorarium of $3,000 for first year and $3,600 for second year fellowships is offered. The prerequisites include a minimum of two years' approved psychiatric training. Applications for fellowships should be filed before Feb. 1, 1955, with Dr. M. Ralph Kaufman, Director, Department of Psychiatry, Mount Sinai Hospital, New York 29.

Symposium on Rectal Cancer.—The New York Cancer Society, at its meeting Jan. 4, 1955, 8:30 p. m. in Hosack Hall, New York Academy of Medicine (Fifth Avenue at 103rd Street), will present a symposium on cancer of the rectum, in which the role of mucosal polyps in lower colonic cancer and indications and contraindications for the preservation of the rectal sphincter in cancer surgery will be considered. Dr. George T. Pack will serve as moderator and Drs. Harry E. Bacon, Philadelphia; Richard K. Gilchrist, Chicago; and Michael R. Deddish, as participants. Physicians and medical students are cordially invited.

Personal.—Dr. Saul A. Schwartz has been appointed assistant clinical professor of internal medicine at the New York Medical College, Flower and Fifth Avenue Hospitals.——Appointment of Detlev W. Bronk, Ph.D., president of the Rockefeller Institute for Medical Research, to the National Advisory Health Council has been announced by Surgeon General Scheele of the U. S. Public Health Service.——Dr. Charles E. Dutchess, who served as medical director of Schenley Laboratories for the past 10 years, has become a consultant to the company. Dr. B. Marr Lanman, recently named head of clinical research for the drug firm, will direct the functions formerly supervised by Dr. Dutchess.

OHIO

Lester Taylor Scholarship.—A $400 scholarship, named for the first president of the Cleveland Health Museum, is available to any qualified graduate student interested in school health education, visual methods in health education, or educational work in museums. Special projects, tailored to the interests and requirements of the candidate, have been set up for completion in from one to three months. All projects must be done on the museum premises under the supervision and direction of its professional staff, and a written report is required. All inquiries should be addressed to Dr. Bruno Gebhard, Director, Cleveland Health Museum, 8911 Euclid Ave., Cleveland 6.

PENNSYLVANIA

Personal.—Dr. Edgar S. Everhart, Harrisburg, retired as chief of the venereal disease division, Pennsylvania Department of Health, Oct. 1, after more than three decades of service with the commonwealth of Pennsylvania in the field of public health.

Rehabilitation Center for Alcoholics.—The new State Rehabilitation Center for Alcoholism at Clarks Summit State Hospital, near Scranton, is now receiving patients. Patients can be admitted for treatment through an order of the county court or the district attorney's office or by referral from one of the four counseling centers recently established under Pennsylvania's alcoholism control program as provided by Act 338 of the 1953 state legislature. Clinician in charge of Clarks Summit Rehabilitation Center is Dr. William F. Lamberti. Dr. Francis M. Ginley, Dunmore, is consultant.

Philadelphia

Bequest to Hospital.—A $30,000 bequest to the Woman's Medical College of Pennsylvania for research in vascular diseases was contained in the will of Mrs. Fannie A. Price of Philadelphia, who died Aug. 16. The fund, to be known as the William N. Price Memorial, is to be used for scholarships, fellowships, or grants-in-aid and may be merged with any other trusts at the discretion of the board of trustees.

Department Chairmen Appointed.—At the University of Pennsylvania School of Medicine, Dr. Dale Rex Coman has been appointed chairman of pathology, the post occupied by the late Dr. Balduin Lucke, and Dr. William J. Erdman has been made chairman of physical medicine and rehabilitation, to succeed Dr. George Morris Piersol, who recently was named dean of the Graduate School of Medicine (THE JOURNAL, Aug. 21, 1954, page 1506).

TENNESSEE

University News.—Dr. Fawzy Z. Akhnoukh of Egypt has been appointed resident physician in the division of pediatrics, University of Tennessee College of Medicine, Memphis, after which service he intends to practice his specialty in Egypt.——Yehia Aziz Habib, Ph.D., who is on leave of absence from the Faculty of Medicine of the University of Alexandria (Egypt), where he is senior lecturer in physiology, has been appointed visiting associate professor of clinical physiology at the University of Tennessee College of Medicine, Memphis. Dr. Habib, whose research work has been primarily in kidney physiology of mammals, will continue this line of work in the clinical physiological laboratories of the Institute of Clinical Investigation under the direction of Richard R. Overman, Ph.D.——The following Memphis physicians have been appointed assistants on the staff of the University of Tennessee College of Medicine in Memphis: Howard B. Hasen, Holt B. Maddux, and William W. Watkins in the department of urologic surgery; James M. Tuholski, Sheldon B. Korones, and Richard Braun Miller in the division of pediatrics; Saul Siegel, Phil E. Orpet Jr., and Richard L. Wooten in the division of medicine; Robert J. Stubblefield, Glenn P. Schoettle, and Wilford H. Gragg Jr. in the division of surgery; and William R. Mitchum in the department of radiology.

TEXAS

Hospital News.—One of the buildings of the John Sealy Hospital, containing rooms and wards for psychiatric patients, has been named the Marvin L. Graves Building, in honor of the late Dr. Marvin L. Graves, formerly professor of internal medicine at the University of Texas Medical Branch, Galveston, and a pioneer in the management of mental disorders in the Southwest.

New Executive Secretary.—C. Lincoln Williston, who has served as assistant executive secretary of the Texas Medical Association since April 1, 1954, was recently made executive secretary. Mr. Williston was manager of public relations for the University of Illinois medical center in Chicago since 1947. He was also chairman of the medical schools section, American College Public Relations Association; lecturer in public relations, Northwestern University; and chairman, section on public relations, Tri-State Hospital Assembly. He served as a captain in the U. S. Air Force on Guam during World War II.

VIRGINIA

All-Night Medical Aid Service.—The Richmond Academy of Medicine has inaugurated an all-night service designed to make certain that a physician will answer any emergency call in the

Richmond area. According to Dr. Benjamin W. Rawles, president, 210 physicians have agreed to take the emergency assignments on a rotating basis. One each night, from 5 p. m. to 8 a. m., will be available through the physician's telephone exchange.

WEST VIRGINIA

New Medical Center.—Construction is under way on the multimillion-dollar basic sciences building of the new University Medical Center in Morgantown. The building will contain more than 1,000 rooms and will provide quarters for instruction in the preclinical years in medicine, nursing, and medical technology, as well as facilities for dentistry and pharmacy. Joined to the building will be a teaching hospital that will contain 400 beds initially. The new medical center will be located on a 145 acre tract within the city limits of Morgantown and about two miles from the main university campus.

Society News.—The West Virginia Society of Anesthesiologists has elected Dr. Newman H. Newhouse, Charleston, president; Dr. John R. Godbey, Charleston, vice-president; and Dr. John F. Morris, Huntington, secretary-treasurer (reelected).——Officers chosen at the annual meeting of the West Virginia Obstetrical and Gynecological Society include Dr. Everett W. McCauley, Bluefield, president; Dr. Charles S. Mahan, Morgantown, vice-president; and Dr. Angelo J. Villani, Welch, secretary-treasurer (reelected).——Dr. John H. Gile, Parkersburg, was elected president at the annual meeting of the West Virginia Diabetes Association; Dr. Halvard Wanger, Shepherdstown, president-elect; Dr. J. Paul Aliff, Charleston, vice-president; and Dr. Delmer J. Brown, Parkersburg, secretary-treasurer.

WISCONSIN

Community Surprise Party.—A community surprise party recently given in honor of Dr. O. Hoyt Epley, New Richmond, marked his 50th year in the practice of medicine. Dr. and Mrs. Epley were presented with two tickets to Europe, and the Pierce–St. Croix County Medical Society entertained them at dinner in Somerset, where Dr. Epley was given a purse and other gifts.

County Society Honored at Civic Dinner.—The Medical Society of Milwaukee County was one of four organizations recently honored at a civic dinner for more than 100 years of continuous service to the community. Dr. James G. Garland, president of the Milwaukee County medical society, gave the response for the society. The other three organizations were the Mutual Life Insurance Company of New York, Poehlmann Baking Company, and the A. Gettelman Brewing Company. The affair was sponsored by the Milwaukee Association of Commerce.

University News.—For health considerations, Dr. John W. Brown, Madison, has been released from his assignment as director of the University of Wisconsin department of preventive medicine and student health. Dr. Archer P. Crosley Jr., who has served for the past two years as staff physician at the Veterans Administration Hospital in Madison and as assistant professor of clinical medicine in the medical school, has been appointed to the post. Dr. Brown will continue as professor of preventive medicine.——Dr. John Harold Juhl, formerly of Minneapolis and recently named associate professor of radiology in the University of Wisconsin Medical School, will serve on a part-time basis at both the Madison Veterans Administration Hospital and the university, where he was assistant professor of radiology from 1950 to 1952.——The University of Wisconsin Medical School, Madison, received a total of $536,606 in gifts and grants for all types of research during the fiscal year July 1, 1953, through June 30, 1954. The largest grants came from the U. S. Public Health Service, which accounted for $271,626. Other large grants came through foundations supported by charity or by membership fees, most of these gifts being specifically earmarked for the type of research to be done. Prominent were the Wisconsin Heart Association, the American Cancer Society, the National Foundation for Infantile Paralysis, and the Wisconsin Association for the Disabled. The National Fund for Medical Education of the American Medical Association contributed $22,485, unrestricted as to use.

GENERAL

Conference on Editorial Problems.—The third Conference on Scientific Editorial Problems will be held Dec. 29 and 30 in room 125, Hilgard Hall, University of California at Berkeley, in conjunction with the annual meeting of the American Association for the Advancement of Science. All persons interested in scientific writing, editing, or publishing are invited to attend.

Service for Physicians Visiting Mexico.—The Association of American Medical Students of the National University of Mexico, Admon, De Correos 45, Apartado 13759, Mexico 1, D. F., has organized a service for physicians who plan to visit Mexico. The students announce that they "will be honored to orientate visiting physicians as to local medical activities."

Conference on Gerontology.—The seventh annual scientific meeting of the Gerontological Society, Inc., in cooperation with the fifth annual Southern Conference of the Institute of Gerontology of the University of Florida, will be held Dec. 28 to 30 at the university in Gainesville. The annual dinner ($3.75 per plate) will be followed by a general meeting, "Recent Advances in Medical Handling of the Geriatric Patient," in the Walker Hall Auditorium. Thursday morning there will be a symposium on social work and aging, and Thursday afternoon a symposium will be presented on later maturity and employment.

Accidental Gas Poisoning.—According to a recent survey among industrial policyholders of the Metropolitan Life Insurance Company, accidental gas poisoning takes an annual toll of about 1,400 lives in the United States; nearly three out of four of those deaths occur in and about the home; and gas ranges or gas heaters are involved in more than half of all the deaths, a common cause of accidents being the turning on of gas jets without lighting them. Other leading causes of gas poisoning include leaky connections or other defects of cooking or heating equipment; incomplete combustion in gas stoves or heaters in poorly ventilated rooms; and running automobile motors in closed household garages.

Study of Cancer Among Navajos.—An investigation to determine the cause of the exceedingly low incidence of cancer among Navajo Indians is being conducted in Arizona and New Mexico by a group of scientists including Dr. Russell S. Boles, Philadelphia, professor of clinical medicine, University of Pennsylvania School of Medicine, Philadelphia, and associate professor of medicine in the university's graduate school of medicine; Dr. Harold R. Sandstead, Bethesda, Md., chief nutritionist of the U. S. Public Health Service; Dr. Noka B. Hon, Bethesda, Md., field investigation officer for the National Cancer Institute; and Dr. Clarence G. Salsbury, commissioner of the Arizona State Department of Health, Phoenix, who instituted the study some years ago.

Conference on Animal Venoms.—An International Conference on Animal Venoms will be held during the 121st annual meeting of the American Association for the Advancement of Science on the University of California campus at Berkeley, Dec. 26 to 31, under the joint sponsorship of A. A. A. S. sections F-zoological sciences and N-medical sciences. Sixty-four scientific papers dealing with poisonous animals and reptiles will be presented before the conference by scientists from Switzerland, Australia, South Africa, India, Austria, Brazil, France, Italy, Africa, Thailand, and the United States. The presentations will include "Snakebite Mortality Problem in the World," "Snake Poisoning in the Sudan," "Bite Symptoms of the Red-Legged Widow Spider," "Pharmacological and Therapeutic Aspects of Toad and Cobra Venoms," "Scorpion Venoms and Antiscorpion Serum," and "Development of a Multivalent Refined Antivenom."

Psychiatry-Pharmacology Session.—At the annual meeting of the American Association for the Advancement of Science in Berkeley, Calif., Dec. 26 to 31, there will be a joint session of the A. A. A. S. section on psychiatry and the American Psychiatric Association to consider "Psychiatry—Pharmacology: Recent Advances." Dr. Jacques S. Gottlieb, University of Miami

School of Medicine, Coral Gables, Fla., will preside over the Thursday morning panel on clinical applications. Dr. Nathan S. Kline, Research Facility, Rockland State Hospital, Orangeburg, N. Y., will preside at the afternoon panel on mechanisms of drugs with behavioral effects, when the following topics will be discussed: "Pharmacology of Chlorpromazine and Reserpine"; "Antagonism Between Mercaline and Chlorpromazine Hydrochloride"; "Mechanism of Lysergic Acid Diethylamide Ceratonin and Related Drugs"; and "Mood Elevation by Barbiturates." Interested members of all professions are invited.

Essay Contest.—The Mississippi Valley Medical Society offers in its 1955 essay contest a cash prize of $100, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents and citizens of the United States. The winner will be invited to present his contribution before the 20th annual meeting of the society in St. Louis, Sept. 28 to 30, 1955. Contributions must be typewritten in English in manuscript form, not to exceed 5,000 words; submitted in five copies; and received not later than May 1. Details may be secured from Dr. Harold Swanberg, Secretary, Mississippi Valley Medical Society, 209-224 W. C. U. Building, Quincy, Ill.

National Sanitation Foundation.—Henry F. Vaughan, Dr.P.H., president of the National Sanitation Foundation, Ann Arbor, Mich., and dean of the University of Michigan School of Public Health, where the foundation has its headquarters, announces the election of 11 new members to the board of trustees, including Drs. William G. Fredrick, director, bureau of industrial health, and Joseph G. Molner, commissioner of health, Detroit Department of Health, and Dr. Leonard A. Scheele, surgeon-general, U. S. Public Health Service, Washington, D. C. The foundation is a nonprofit organization, established in 1945 "to promote a better quality of American living through cooperative action by community, industrial, and health leaders toward improvement of the total environment, including pure water, sufficient in quantity for all purposes; clean air; noise control; satisfactory disposal of wastes, including radioactive wastes and synthetic chemicals; safe food and beverages; and adequate shelter of all types in pleasant surroundings."

Labor-Management Medical Administrators.—The Association of Labor-Management Medical Care Program Administrators was organized at a conference in Buffalo, Oct. 11, to bring together the medical and lay administrators of medical care programs sponsored by labor unions or labor-management health and welfare funds. The association's chief objectives are said to be the study and sharing of experiences of the various labor health programs and the promotion of standards for high-quality medical care. Professional consultation to unions and union-management groups will be offered. The newly elected executive board of the association includes: president, Dr. Morris A. Brand, medical director, Sidney Hillman Health Center, New York; vice-president, Dr. Frank P. Guidotti, medical director, Hotel Trades Health Center, New York; and secretary-treasurer, Dr. Herbert K. Abrams, medical director, Union Health Service, Inc., Chicago. Communications should be addressed to the Secretary-Treasurer, Dr. Herbert K. Abrams, 509 S. Wabash Ave., Chicago 5.

Society News.—Officers of the **Association of Life Insurance Medical Directors** for the year 1954-1955 include: Dr. Richard L. Willis, New York, president; Dr. Ralph R. Simmons, Des Moines, Iowa, president-elect; Dr. Edson E. Getman, New York, vice-president; Dr. Henry B. Kirkland, Newark, N. J., secretary; and Dr. J. Grant Irving, Hartford, Conn., treasurer.——Newly elected officers of the **American Clinical and Climatological Association** include: Dr. Henry M. Thomas Jr., Baltimore, president; Drs. James M. Faulkner, Boston, and Johnson McGuire, Cincinnati, vice-presidents; Dr. Marshall N. Fulton, Providence, R. I., secretary-treasurer; and Dr. W. David Strayhorn, Nashville, Tenn., recorder.——The annual meeting of the **American College of Radiology** will be held in Chicago at the Drake Hotel, Feb. 9 to 12, 1955. The board of chancellors will meet Wednesday and Thursday; on Friday the annual meeting and banquet, preceded by the college convocation, will be held; and the 22nd annual Conference of Teachers of Clinical Radiology will convene on Saturday.——At the annual meeting of the **Inter-Society Cytology Council** Dr. Arthur T. Hertig, Boston, was elected president; Drs. George N. Papanicolaou, New York, Lewis C. Scheffey, Philadelphia, and Arthur P. Stout, New York, vice-presidents; Dr. Paul F. Fletcher, St. Louis, secretary-treasurer; and Dr. John B. Graham, Boston, assistant secretary. The next annual meeting will be held in Cleveland in November, 1955.

Conference on Premedical and Predental Education.—Alpha Epsilon Delta, national premedical honor society, will sponsor a regional conference on premedical and predental education at the Biltmore Hotel, New York, Jan. 7 and 8, 1955. Lloyd R. Gribble, Ph.D., national AEΔ president and assistant dean, college of arts and sciences, West Virginia University, Morgantown, will preside at the symposium, "Preparation for Medical and Dental Education in the Liberal Arts College," Friday morning. "The Medical Educators' Evaluation of the Report" will be presented by Dr. Donald G. Anderson, dean, University of Rochester (N. Y.) School of Medicine and Dentistry; "Objectives in Preprofessional Dental Education" by Lester W. Burket, D.D.S., M.D., dean, University of Pennsylvania School of Dentistry; and "Preprofessional Education in the Liberal Arts College" by Delmar Leighton, M.B.A., dean of students, Harvard College, Cambridge, Mass. The afternoon will be devoted to discussions of the report. Eric H. Faigle, Ph.D., dean, liberal arts college, Syracuse University, will be toastmaster for the conference dinner at 7 p. m. (price $7.50, including gratuities and tax). An address, "Medical Education Is Graduate Education," will be delivered by Dr. Vernon W. Lippard, dean, Yale University School of Medicine, New Haven, Conn., who is president of the Association of American Medical Colleges. Dinner reservations may be made through Alpha Epsilon Delta, 7 Brookside Circle, Bronxville 8, N. Y.

Training Program in Rehabilitation.—A seven month training program for rehabilitation center directors or administrators will be held at the Institute for the Crippled and Disabled, New York, in collaboration with the Office of Vocational Rehabilitation, Washington, D. C. The scheduled starting date is Jan. 1, 1955; however, delay in recruiting may necessitate postponement to Feb. 1. The training will consist of an initial period at the institute, followed by three on-the-job placements at selected rehabilitation facilities. All phases of rehabilitation center administration will be covered during the periods the trainees are at the institute, in addition to such topics as chronic disease as a socioeconomic problem; rehabilitation centers—history, types, organization; disciplines contributing to rehabilitation; coordination of services; and community considerations. Candidates (men or women not under 30 years of age, with a minimum educational requirement of a bachelor's degree) should have had at least three years' experience in rehabilitation and its constituent fields. Trainees should possess such personality attributes as feeling for leadership, personal stability, resourcefulness, tact, and effectiveness. A monthly stipend of $250 for the seven month period will be paid to each trainee. Travel expense between New York City and the locations of on-the-job placement centers will be paid by the institute. Other expenses will be borne by the trainee. Applications should be submitted to the Director, Institute for the Crippled and Disabled, 400 First Ave., New York 10.

Fellowships in Radiological Physics and Industrial Hygiene.—Applications for U. S. Atomic Energy Commission fellowships in radiological physics and industrial hygiene for the 1955-1956 school year are being received by the Oak Ridge Institute of Nuclear Studies. The Industrial Hygiene Fellowships Program supports persons studying for the master's degree in this field at either the Harvard School of Public Health, Boston, or the University of Pittsburgh Graduate School of Public Health. Radiological physics fellowships are carried out in three separate programs as follows: at Vanderbilt University, Nashville, Tenn.,

and Oak Ridge (Tenn.) National Laboratory; at the University of Rochester (N. Y.) and Brookhaven National Laboratory, Upton, Long Island, N. Y.; and at the University of Washington and the Hanford Works. In each case, nine months of course work at the university are followed by three months of additional study and field training at the cooperating AEC installation. Up to 25 fellows may be appointed in each of the three programs, and course work may be applied toward an advanced degree. Six-month extensions may be granted in some cases for completion of work on the master's degree. Basic stipend for both fellowships is $1,600, with an allowance of $350 for a spouse and $350 for each dependent child. Tuition and laboratory fees are paid as a part of the fellowship. Industrial hygiene fellows may receive an additional allowance of $200 if they have already completed a year of graduate study or have appropriate work experience. Information may be obtained from the Fellowship Office, University Relations Division, Oak Ridge Institute of Nuclear Studies, P. O. Box 117, Oak Ridge, Tenn.

MEETINGS

AMERICAN MEDICAL ASSOCIATION: Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secretary.

1955 Annual Meeting, Atlantic City, N. J., June 6-10.

1955 Clinical Meeting, Boston, Nov. 29-Dec. 2.

1956 Annual Meeting, Chicago, June 11-15.

1956 Clinical Meeting, Seattle, Nov. 27-30.

1957 Annual Meeting, New York, June 3-7.

ANNUAL CONGRESS ON INDUSTRIAL HEALTH, Hotel Shoreham, Washington, D. C., Jan. 24-26. Dr. Carl M. Peterson, 535 North Dearborn St., Chicago 10, Secretary.

ANNUAL CONGRESS ON MEDICAL EDUCATION AND LICENSURE, Palmer House, Chicago, Feb. 5-8. Dr. Edward L. Turner, 535 N. Dearborn St., Chicago 10, Secretary.

AMERICAN ACADEMY OF ALLERGY, Hotel Statler, New York, Feb. 7-9. Dr. Francis C. Lowell, 65 East Newton St., Boston, Secretary.

AMERICAN ACADEMY OF OCCUPATIONAL MEDICINE, Hotel Warwick, Philadelphia, Feb. 10-11. Dr. Leonard J. Goldwater, 600 West 168th St., New York 32, Secretary.

AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS, Hotel Statler, Los Angeles, Jan. 29-Feb. 3. Dr. J. R. Norcross, 122 S. Michigan Blvd., Chicago 3, Secretary.

AMERICAN COLLEGE OF RADIOLOGY, Drake Hotel, Chicago, Feb. 11-12. Mr. William C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secretary.

CENTRAL SURGICAL ASSOCIATION, Drake Hotel, Chicago, Feb. 17-19. Dr. Robert M. Zollinger, University Hospital, Columbus 10, Ohio, Secretary.

COLLEGE OF AMERICAN PATHOLOGISTS, Drake Hotel, Chicago, Feb. 5-6. Dr. Arthur H. Dearing, 203 N. Wabash Ave., Chicago 1, Executive Secretary.

EASTERN SECTION, AMERICAN LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL SOCIETY, Hotel Warwick, Philadelphia, Jan. 7. Dr. Benjamin H. Shuster, 1824 Pine St., Philadelphia 3, Chairman.

GERONTOLOGICAL SOCIETY, University of Florida, Gainesville, Fla., Dec. 28-30. Dr. Nathan W. Shock, Baltimore City Hospitals, Baltimore 24, Secretary.

INTERNATIONAL POST-GRADUATE MEDICAL ASSEMBLY OF SOUTHWEST TEXAS, San Antonio, Texas, Jan. 24-26. Dr. John M. Smith Jr., P.O. Box 2445, San Antonio 6, Texas, Secretary.

MIDDLE SECTION, AMERICAN LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL SOCIETY, Sheraton-Cadillac Hotel, Detroit, Jan. 24. Dr. James E. Croushore, 3001 West Grand Blvd., Detroit 2, Chairman.

NORTHWEST SOCIETY FOR CLINICAL RESEARCH, Vancouver, B. C., Jan. 22. Dr. Arthur L. Rogers, 1216 S. W. Yamhill St., Portland 5, Oregon, Secretary.

REGIONAL MEETINGS, AMERICAN COLLEGE OF PHYSICIANS:

DELAWARE, Wilmington, Feb. 5. Dr. Lewis B. Flinn, 503 Delaware Ave., Wilmington 1, Chairman.

SOUTHERN CALIFORNIA, San Diego, Feb. 12-13. Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Executive Secretary.

SECTIONAL MEETINGS, AMERICAN COLLEGE OF SURGEONS:

Texas, Galveston, Buccaneer and Galvez Hotels, Jan. 17-19. Dr. Robert M. Moore, 900 Strand Street, Galveston, Chairman.

SOCIETY OF UNIVERSITY SURGEONS, Hotel Shamrock, Houston, Texas, Feb. 9-12. Dr. C. Rollins Hanlon, 1325 S. Grand Blvd., St. Louis, Secretary.

SOUTH ATLANTIC ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS, Williamsburg, Va., Feb. 10-12. Dr. C. H. Mauzy, Bowman Gray School of Medicine, Winston-Salem, N. C., Secretary.

SOUTHERN NEUROSURGICAL SOCIETY, Dinkler-Tutwiler Hotel, Birmingham, Ala., Feb. 18-19. Dr. William F. Meacham, Vanderbilt University Hospital, Nashville, Tenn., Secretary.

SOUTHERN SECTION, AMERICAN LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL SOCIETY, Medical School Auditorium, Charlottesville, Va., Jan. 24. Dr. G. Slaughter Fitz-Hugh, 104 East Market St., Charlottesville, Va., Chairman.

WESTERN SECTION, AMERICAN FEDERATION FOR CLINICAL RESEARCH, Carmel, Calif., Jan. 27. Dr. Arthur B. French, University of Utah College of Medicine, Salt Lake City, Secretary.

WESTERN SECTION, AMERICAN LARYNGOLOGICAL, RHINOLOGICAL AND OTOLOGICAL SOCIETY, The Town House, Los Angeles, Jan. 15-16. Dr. Victor Goodhill, 2007 Wilshire Blvd., Los Angeles 57, Vice President.

WESTERN SOCIETY FOR CLINICAL RESEARCH, Carmel, Calif., Jan. 28-29. Dr. Herbert N. Hultgren, Stanford Hospital, San Francisco 15, Secretary.

FOREIGN AND INTERNATIONAL

AUSTRALASIAN MEDICAL CONGRESS, Sydney, N.S.W., Australia, Aug. 20-27. For information write: Federal Council of the B.M.A. in Australia, 135 Macquaire St., Sydney, N.S.W., Australia.

BRITISH MEDICAL ASSOCIATION, Representative Meeting, London, England, June 1-4. Dr. A. Macrae, B.M.A. House, Tavistock Square, London, W.C.1, England, Secretary.

CANADIAN AND BRITISH MEDICAL ASSOCIATIONS, Joint Meeting, Toronto, Canada, June 20-22. Dr. Arthur D. Kelly, 244 St. George St., Toronto, Canada, General Secretary.

COMMONWEALTH HEALTH AND TUBERCULOSIS CONFERENCE, Royal Festival Hall, London, England, June 21-25. Mr. J. H. Harley Williams, Tavistock House North, Tavistock Square, London, W.C.1, England, Secretary General.

CONGRESS OF INTERNATIONAL ASSOCIATION OF APPLIED PSYCHOLOGY, London, England, July 18-23. Dr. C. B. Frisby, National Institute of Industrial Psychology, 14 Welbeck St., London, W.1, England, President.

CONGRESS OF INTERNATIONAL ASSOCIATION OF PSYCHOTECHNOLOGY, London, England, July 18-23. For information write: Dr. C. B. Frisby, Director, National Institute of Industrial Psychology, 14 Welbeck St., London, W.1, England.

CONGRESS OF THE INTERNATIONAL ASSOCIATION FOR THE STUDY OF THE BRONCHI, Stockholm, Sweden, June 18-19. For information write: Dr. J. M. Lemoine, 187 boulevard St. Germain, Paris 7e, France.

CONGRESS OF INTERNATIONAL DIABETES FEDERATION, Cambridge, England, July 4-8. Mr. James G. L. Jackson, 152 Harley St., London, W.1, England, Executive Secretary General.

CONGRESS OF INTERNATIONAL SOCIETY OF SURGERY, Copenhagen, Denmark, July 23-29. Dr. L. Dejardin, 141 rue Belliard, Brussels, Belgium, General Secretary.

EUROPEAN CONGRESS ON RHEUMATISM, Scheveningen, The Hague, Netherlands, June 13-17. Dr. H. van Swaay, Pieter Bothstraat 12, The Hague, Netherlands, Secretary.

HEALTH CONGRESS OF THE ROYAL SANITARY INSTITUTE, Bournemouth, England, April 26-29. Mr. P. Arthur Wells, Royal Sanitary Institute, 90 Buckingham Palace Road, London, S.W.1, England, Secretary.

INTER-AMERICAN CONGRESS OF RADIOLOGY, Shoreham Hotel, Washington, D. C., U. S. A., April 24-29. Dr. Eugene P. Pendergrass, 3400 Spruce St., Philadelphia 4, Pa., U. S. A., Secretary-General.

INTER-AMERICAN SESSION, AMERICAN COLLEGE OF SURGEONS, Universidad Mayor de San Marcos de Lima, Lima, Peru, S. A., Jan. 11-14. Dr. Michael L. Mason, 40 East Erie St., Chicago 11, Ill., U. S. A., Secretary.

INTERNATIONAL ANATOMICAL CONGRESS, Paris, France, July 25-30. Prof Gaston Cordier, 45, rue des Saints-Pères, Paris 6e, France, Secretary-General.

INTERNATIONAL ANESTHESIA RESEARCH SOCIETY, Washington, D. C., U.S.A., Oct. 24-27. For information write: Dr. William Friend, 515 Nome Avenue, Akron 20, Ohio, U. S. A.

INTERNATIONAL CONGRESS OF ALLERGOLOGY, Rio de Janeiro, Brazil, S. A., Nov. 6-12. Dr. Bernard N. Halpern, 197 boulevard St. Germain, Paris 7e, France, Secretary General.

INTERNATIONAL CONGRESS OF ANGIOLOGY AND HISTOPATHOLOGY, Fribourg, Switzerland, Sept. 2—. For information write: Dr. Gerson, 4 rue Pasquier, Paris 8e, France.

INTERNATIONAL CONGRESS OF BIOCHEMISTRY, Brussels, Belgium, Aug. 1-6. Prof. C. Liebecq, 17 Place Delcour, Liège, Belgium, Secretary-General.

INTERNATIONAL CONGRESS OF COMPARATIVE PATHOLOGY, Lausanne, Switzerland, May 26-31. Professor Hauduroy, 19 rue Cesar Roux, Lausanne, Switzerland, Secretary-General.

INTERNATIONAL CONGRESS OF CRIMINOLOGY, London, England, Sept. 11-18. For information write: Dr. Carroll, 28 Weymouth St., London, W.1, England.

INTERNATIONAL CONGRESS OF PLASTIC SURGERY, Stockholm, Sweden, Aug. 1-4, and Uppsala, Sweden, Aug. 5. Dr. Tord Skoog, Uppsala, Sweden, General Secretary.

INTERNATIONAL CONGRESS OF UROLOGY, Athens, Greece, April 10-18. Dr. Z. Kaires, 25, rue Voukourestion, Athens, Greece, Secretary General.

INTERNATIONAL HOSPITAL CONGRESS, Lucerne, Switzerland, May 30-June 3. Capt. J. E. Stone, International Hospital Federation, 10 Old Jewry, London, E.C.2, England, Hon. Secretary.

INTERNATIONAL MEDICAL CONGRESS, Verona, Italy, Sept. 1-4. For information write: % Offices of the International Verona Fair, Piazza Bra., Verona, Italy.

INTERNATIONAL SURGICAL CONGRESS, Geneva, Switzerland, May 23-26. Dr. Max Thorek, 1516 Lake Shore Drive, Chicago, Illinois, U. S. A., Secretary-General.

INTERNATIONAL SYMPOSIUM ON CARDIOVASCULAR SURGERY, Henry Ford Hospital, Detroit, Michigan, U. S. A., March 17-19. Dr. Conrad R. Lam, 2799 West Grand Boulevard, Detroit 2, Michigan, U. S. A., Chairman of Program Committee.

INTERNATIONAL SYNDICATE OF GYNECOLOGISTS AND OBSTETRICIANS, Meeting Hall of Medical Societies, Paris, France, June 27-28. Dr. Jacques Courtois, 1, rue Racine, Saint-Germain-en-Laye (S & O), France, Secretary-General.

JAPAN MEDICAL CONGRESS, Kyoto University and Kyoto Prefectural Medical College, Kyoto, Japan, April 1-5. Dr. Mitsuharu Goto, University Hospital, Medical Faculty of Kyoto University, Kyoto, Japan, Secretary-General.

LATIN AMERICAN CONGRESS OF PHYSICAL MEDICINE, Lima, Peru, S. A., Feb. 14-19. Dr. Cassius Lopez de Victoria, 176 East 71st St., New York 21, N. Y., U.S.A., Executive Director.

LATIN AMERICAN ELECTROENCEPHALOGRAPHICAL CONGRESS, Montevideo, Uruguay, S. A., March 21-24. For information write: Dr. R. Arana-Iniquez, Convencion 1287, Montevideo, Uruguay, S. A.

LATIN AMERICAN NEUROSURGICAL CONGRESS, Montevideo, Uruguay, S.A., March 21-24. For information write: Dr. R. Arana-Iniquez, Convencion 1287, Montevideo, Uruguay, S. A.

MIDDLE EAST MEDICAL ASSEMBLY, Campus of American University of Beirut, Beirut, Lebanon, April 22-24. Dr. John L. Wilson, American University of Beirut, Beirut, Lebanon, Chairman.

NATIONAL CONGRESS OF TUBERCULOSIS AND SILICOSIS, Mexico, D. F., Mexico, Jan. 23-29. Dr. Jose Nava Gonzalez, Balderas 32-312, Ap. Postal 7267, Mexico, D. F., Mexico, Secretary General.

NEURORADIOLOGIC SYMPOSIUM, London, England, Sept. 13-17. Dr. R. D. Hoare, National Hospital, Queen Square, London, W.C.1, England, Secretary.

PAN-AMERICAN ACADEMY OF GENERAL PRACTICE, Lima, Peru, S. A., Feb. 11-25. Dr. Arturo Martinez, 54 East 72nd St., New York 21, N. Y., U. S. A., Secretary.

WORLD MEDICAL ASSOCIATION, Vienna, Austria, Sept. 20-26. Dr. Louis H. Bauer, 345 East 46th St., New York 17, N. Y., U. S. A., Secretary-General.

EXAMINATIONS AND LICENSURE

BOARDS OF MEDICAL EXAMINERS

ALABAMA: *Examination.* Montgomery, June 21-23. Sec., Dr. D. G. Gill, 537 Dexter Ave., Montgomery 4.

ARIZONA:* *Examination and Reciprocity.* Phoenix, Jan. 12-14, and April 13-15. Ex. Sec., Mr. Robert Carpenter, 401 Security Bldg., Phoenix.

ARKANSAS:* *Examination.* Little Rock, June 9-10. Sec., Dr. Joe Verser, Harrisburg.

COLORADO:* *Examination.* Denver, June 14-15. *Reciprocity.* Denver, Jan. 11. Exec. Sec., Mrs. Beulah H. Hudgens, 831 Republic Bldg., Denver 2.

CONNECTICUT:* *Examination.* Hartford, Mar. 8-9. Sec. to the Board, Dr. Creighton Barker, 160 St. Ronan St., New Haven. *Homeopathic. Examination and Reciprocity.* Derby, March 8-9. Sec., Dr. Donald A. Davis, 38 Elizabeth St., Derby.

DELAWARE: *Examination and Reciprocity.* Dover, Jan. 11-13. Sec., Dr. J. S. McDaniel, 229 S. State St., Dover.

FLORIDA:* *Examination.* Jacksonville, June 26-28. Sec., Dr. Homer L. Pearson, 901 N.W. 17th St., Miami.

GEORGIA: *Examination and Reciprocity.* Atlanta and Augusta, June. Sec., Mr. R. C. Coleman, 111 State Capitol, Atlanta 3.

IDAHO: *Examination and Endorsement.* Boise, Jan. 10-12. Exec. Sec., Mr. Armand L. Bird, 364 Sonna Bldg., Boise.

ILLINOIS: *Examination and Reciprocity.* Chicago, Jan. 25-27. Supt. of Regis., Mr. Fredric B. Selcke, Capitol Bldg., Springfield.

INDIANA: *Examination.* Indianapolis, June 21-23. Exec. Sec., Miss Ruth V. Kirk, 538 K. of P. Building, Indianapolis.

MAINE: *Examination and Reciprocity.* Portland, Mar. 8-9. Sec., Dr. Adam P. Leighton, 192 State St., Portland.

MASSACHUSETTS: *Examination.* Boston, Jan. 18-21. Sec., Dr. Robert C. Cochrane, Room 37, State House, Boston.

MICHIGAN:* *Examination.* Ann Arbor and Detroit, June 15-17 (tentative). Sec., Dr. J. Earl McIntyre, 118 Stevens T. Mason Bldg., Lansing 8.

MINNESOTA:* *Examination and Reciprocity.* Minneapolis, Jan. 18-20. Sec., Dr. F. H. Magney, 230 Lowry Medical Arts Bldg., St. Paul 2.

MISSISSIPPI: *Reciprocity.* Jackson, December. Asst. Sec., Dr. R. Whitfield, Old Capitol, Jackson 113.

MISSOURI: *Examination.* Jefferson City, Feb. 17-18. Exec. Sec., Mr. John A. Hailey, State Capitol Bldg., Box 4, Jefferson City.

NEBRASKA:* *Examination.* Omaha, June. Director, Bureau of Examining Boards, Mr. Husted K. Watson, State Capitol Bldg., Room 1009, Lincoln 9.

NEVADA:* *Examination and Reciprocity.* Reno, Jan. 4. Sec., Dr. G. H. Ross, 112 N. Curry St., Carson City.

NEW HAMPSHIRE: *Examination and Reciprocity.* Concord, Mar. 9. Sec., Dr. John S. Wheeler, 107 State House, Concord.

NEW MEXICO:* *Examination and Reciprocity.* Santa Fe, Apr. 11-12. Sec., Dr. R. C. Derbyshire, 227 E. Palace Ave., Santa Fe.

NEW YORK: *Examination.* New York City, Albany, Buffalo, and Syracuse, Feb. 15-18. Sec., Dr. Stiles D. Ezell, 23 S. Pearl St., Albany 7.

NORTH CAROLINA: *Reciprocity and Endorsement.* Winston-Salem, Jan. 10. Sec., Dr. Joseph J. Combs, Professional Bldg., Raleigh.

NORTH DAKOTA: *Examination.* Grand Forks, Jan. 5-8. *Reciprocity.* Grand Forks, Jan. 8. Sec., Dr. C. J. Glaspel, Grafton.

OKLAHOMA:* *Examination.* Oklahoma City, June 7-8. Sec., Dr. C. Gallagher, 813 Braniff Bldg., Oklahoma City.

OREGON:* *Examination and Reciprocity.* Portland, Jan. 6-8. Ex. Sec., Mr. Howard I. Bobbitt, 609 Failing Bldg., Portland 4.

PENNSYLVANIA: *Examination.* Philadelphia, January. Acting Sec., Mrs. Marguerite B. Steiner, Box 911, Harrisburg.

RHODE ISLAND:* *Examination.* Providence, Jan. 7-8. Admin. of Prof. Regulation, Mr. Thomas B. Casey, 366 State Office Bldg., Providence.

SOUTH DAKOTA:* *Examination and Reciprocity.* Sioux Falls, Jan. 18-19. Exec. Sec., Mr. John C. Foster, 300 First National Bank Bldg., Sioux Falls.

UTAH: *Reciprocity.* Salt Lake City, Feb. 15. *Examination.* Salt Lake City, July. Director, Mr. Frank E. Lees, 324 State Capitol Bldg., Salt Lake City.

VERMONT: *Examination and Endorsement.* Burlington, Jan. 27-29. Sec., Dr. F. J. Lawliss, Richford.

WASHINGTON:* *Examination and Reciprocity.* Seattle, Jan. 10-12. Sec., Mr. Edward C. Dohm, Olympia.

WEST VIRGINIA: *Examination and Reciprocity.* Charleston, Jan. 10. Sec., Dr. Newman H. Dyer, State Office Bldg. No. 3, Charleston 5.

WISCONSIN:* *Examination and Reciprocity.* Madison, Jan. 11-13. Sec., Dr. Thomas W. Tormey Jr., Room 1140, State Office Bldg., Madison 2.

WYOMING: *Examination and Reciprocity.* Cheyenne, Feb. 7. Sec., Dr. Franklin D. Yoder, State Office Bldg., Cheyenne.

ALASKA:* On application. Sec., Dr. W. M. Whitehead, 172 South Franklin St., Juneau.

GUAM: The Commission on Licensure will meet whenever a candidate appears or submits his credentials. Sec., Dr. Benedict Cooper, Agana.

HAWAII: *Examination.* Honolulu, Jan. 10-13. Sec., Dr. I. L. Tilden, 1020 Kapiolani St., Honolulu.

BOARDS OF EXAMINERS IN THE BASIC SCIENCES

ARKANSAS: *Examination.* Little Rock, May 3-4. Sec., Mr. S. C. Dellinger, Zoology Dept., University of Arkansas, Fayetteville.

COLORADO: *Examination and Reciprocity.* Lincoln and Denver, Mar. 2-3. Sec., Dr. Esther B. Starks, 1459 Ogden St., Denver.

CONNECTICUT: *Examination.* New Haven, Feb. 12. Address: State Board of Healing Arts, 258 Bradley St., New Haven 10.

FLORIDA: *Examination.* Miami and Gainesville, May 14. Sec., Mr. M. W. Emmel, Box 340, University of Florida, Gainesville.

IOWA: *Examination and Reciprocity.* Des Moines, Jan. 11. Sec., Dr. Ben H. Peterson, Coe College, Cedar Rapids.

MICHIGAN: *Examination and Reciprocity.* Detroit and Ann Arbor, Feb. 11-12. Sec., Mrs. Anne Baker, 410 W. Michigan Ave., Lansing 15.

MINNESOTA: *Examination.* Minneapolis, Jan. 4-5. Sec., Dr. Raymond N. Bieter, 105 Millard Hall, University of Minnesota, Minneapolis.

NEBRASKA: *Examination and Reciprocity.* Omaha, Jan. 11-12. Sec., Mr. Husted K. Watson, Room 1009, State Capitol Bldg., Lincoln 9.

NEVADA: *Examination.* Reno, Jan. 4. Sec., Dr. Donald G. Cooney, Box 9005, University Station, Reno.

NEW MEXICO: *Examination and Reciprocity.* Santa Fe, Jan. 16. Sec., Mrs. Marguerite Cantrell, Box 1522, Santa Fe.

OKLAHOMA: Oklahoma City, April 7-8. Sec., Dr. C. Gallagher, 813 Braniff Bldg., Oklahoma City.

OREGON: *Examination.* Portland, March 5, June 4, Sept. 10, and Dec. 3. Sec., Mr. Charles D. Byrne, State Board of Higher Education, Eugene.

RHODE ISLAND: *Examination.* Providence, Feb. 9. Admin. of Prof. Regulation, Mr. Thomas B. Casey, 366 State Office Bldg., Providence.

TENNESSEE: *Examination and Reciprocity.* Memphis, Jan. 3-4. Sec., Dr. O. W. Hyman, 874 Union Ave., Memphis.

TEXAS: *Examination and Reciprocity.* Austin and other locations, April. Sec., Bro. Raphael Wilson, 407 Perry-Brooks Bldg., Austin.

WASHINGTON: *Examination.* Seattle, Jan. 5-6. Sec., Mr. Edward C. Dohm, Olympia.

WISCONSIN: *Examination.* Madison, March 12, and Milwaukee, May 14. Sec., Mr. William H. Barger, 621 Ransom St., Ripon.

ALASKA: On application. Juneau or other towns in Territory as decided by Board. *Reciprocity.* On application. Sec., Dr. C. Earl Albrecht, Box 1931, Juneau.

*Basic Science Certificate required.

DEATHS

Schwentker, Francis Frederic, Baltimore; born in Schenectady, N. Y., Feb. 13, 1904; Johns Hopkins University School of Medicine, Baltimore, 1929; interned in pediatrics at Johns Hopkins Hospital, where later he was assistant resident pediatrician, resident pediatrician, and, from 1946 until the time of his death, pediatrician-in-chief; from 1935 to 1936 resident physician, Sydenham Hospital; from July 1, 1946, until his death, professor of pediatrics at his alma mater; from 1931 to 1934 associated with the Rockefeller Institute for Medical Research in New York City; in 1936 became director of medical research for the Baltimore Health Department; held that post until 1938, when he was named to the staff of the International Health Division of the Rockefeller Foundation; in 1940 was made a member of the Rockefeller Health Commission to Europe; later appointed consultant on epidemic diseases to the Secretary of War; in 1942 entered the Navy as a consultant in pediatrics, serving as a commander; certified by the National Board of Medical Examiners; specialist certified by the American Board of Pediatrics; member of the American Pediatric Society, Association of American Physicians, and the Society of American Bacteriologists; in 1949 president of the Society for Pediatric Research; president of the Maryland Rheumatic Fever and Heart Association; chairman, committee on education, American Council on Rheumatic Fever; member of the medical advisory council, Masonic Foundation for Medical Research and Human Welfare; member of the subcommittee on infectious diseases, National Research Council; member of the committee on research fellowships in pediatrics, National Foundation for Infantile Paralysis; director of the Harriet Lane Home for Invalid Children, an affiliate of Johns Hopkins Hospital; consulting editor of *Medicine;* on the editorial board of *Pediatrics;* in 1950 received the doctor of science degree from Union College in Schenectady, N. Y.; died Nov. 8, aged 50.

Healy, William Patrick ⊕ New York City; born in Bridgeport, Conn., March 17, 1876; Johns Hopkins University School of Medicine, Baltimore, 1900; formerly associate professor of clinical obstetrics and gynecology at Cornell University Medical College; at one time dean and professor of gynecology at Fordham University School of Medicine, and on the faculty of Columbia University College of Physicians and Surgeons; specialist certified by the American Board of Obstetrics and Gynecology; past president and vice-president of the American Gynecological Society; past president of the American Radium Society, from which he received the Janeway medal in June, 1942; delivered the Janeway lecture, "The Role of the Gynecologist in the Field of Cancer," and was given a prize for outstanding contributions in the field of radium therapy; in 1926 was president of the Medical Society of the County of New York; fellow of the American College of Radiology and the American College of Surgeons; at various times served on the staffs of the Memorial Center for Cancer and Allied Diseases, the Roosevelt, Misericordia, Fordham, and Bronx Maternity hospitals, New York Infirmary for Women and Children, and the New York Polyclinic Hospital in New York City, Caledonian Hospital in Brooklyn, Fitkin Memorial Hospital in Neptune, N. J., St. Luke's Hospital in Newburgh, N. Y., Elizabeth A. Horton Memorial Hospital in Middletown, N. Y., Lawrence Hospital in Bronxville, N. Y., Northern Westchester Hospital in Mount Kisco, N. Y., St. Joseph's and St. John's Riverside hospitals in Yonkers, N. Y., Sea View Hospital in Staten Island, N. Y., and Monmouth Memorial Hospital in Long Branch, N. J.; died Nov. 8, aged 78, of heart disease.

Scheinker, Ilya Mark ⊕ New York City; Medizinische Fakultät der Universität, Vienna, Austria, 1931; member of the Ohio State Medical Association; specialist certified by the American Board of Psychiatry and Neurology; member of the American Association of Neuropathologists and the Association for Research in Nervous and Mental Diseases; since March 23 associate professor of neurology at New York Medical College, Flower and Fifth Avenue Hospital; formerly assistant professor of neuropathology at the University of Cincinnati College of Medicine; author of "Medical Neuropathology"; died Aug. 24, aged 52, of a heart attack.

Goeckerman, William Henry ⊕ Los Angeles; born in Milwaukee June 17, 1884; Wisconsin College of Physicians and Surgeons, Milwaukee, 1906; emeritus clinical professor of medicine (dermatology and syphilology) University of Southern California School of Medicine; specialist certified by the American Board of Dermatology and Syphilology; member of the American Dermatological Association; for many years associated with the Mayo Clinic and the University of Minnesota Graduate School in Rochester, Minn.; on the staffs of the California and St. Vincent's hospitals; died in Whittier, Calif., Nov. 8, aged 70, of carcinoma.

Biddle, Sydney Geoffrey ⊕ Philadelphia; born June 16, 1889; University of Pennsylvania School of Medicine, Philadelphia, 1917; specialist certified by the American Board of Psychiatry and Neurology; certified by the National Board of Medical Examiners; member of the American Psychoanalytic Association and the American Psychiatric Association; past president of the Philadelphia Psychoanalytic Society; chairman of the board of directors of the Institute of the Philadelphia Association for Psychoanalysis; served during World War I; died in the Chester County Hospital in West Chester, Oct. 28, aged 65, of coronary disease.

Annis, Homer Burnham ⊕ Bluffton, Ind.; Rush Medical College, Chicago, 1907; died Nov. 1, aged 72, of coronary thrombosis.

Babcock, Harry L., Whitehouse, Ohio; Ohio Medical University, Columbus, 1898; served during World War I; died in Fort Wayne (Ind.) Veterans Hospital Sept. 24, aged 82, of intestinal obstruction.

Baker, James Thompson ⊕ Hickman, Ky.; Louisville (Ky.) Medical College, 1896; died Nov. 1, aged 83.

Bauman, Louis ⊕ New York City; Columbia University College of Physicians and Surgeons, New York, 1901; emeritus assistant professor of clinical medicine at his alma mater; specialist certified by the American Board of Internal Medicine; member of the American Society for Clinical Investigation; past president of the New York Diabetes Association; on the staff of the Presbyterian Hospital; died in New Rochelle, Nov. 1, aged 74, of coronary thrombosis.

Bayliss, Frank Perrin ⊕ Syracuse, N. Y.; Syracuse University College of Medicine, 1905; died Oct. 17, aged 78.

Bergin, Joseph David, Worcester, Mass.; Boston University School of Medicine, 1940; certified by the National Board of Medical Examiners; specialist certified by the American Board of Urology; formerly assistant in urology at his alma mater; received numerous ribbons for service during World War II; on the staffs of the Worcester City and St. Vincent's hospitals; died Oct. 7, aged 39, of skull fracture received in an automobile accident.

Berry, Winfield Scott, Prentiss, Miss.; Medical Department of Tulane University of Louisiana, New Orleans, 1912; on the staff of the Jefferson Davis County Hospital; died Oct. 10, aged 68, of coronary thrombosis.

Bishop, Benjamin Clyde ⊕ Greenville, S. C.; Medical College of the State of South Carolina, Charleston, 1926; past president of the Greenville County Medical Society; on the staffs of St. Francis Hospital and the Greenville General Hospital, where he died Oct. 5, aged 54, of hepatitis.

Bjorneby, Peter Cornelius, Minneapolis; Minneapolis College of Physicians and Surgeons, 1897; served during World War I; for many years practiced in Bagley, Minn., where he served as mayor and county coroner; died in the Fairview Hospital Oct. 14, aged 84, of coronary sclerosis.

⊕ Indicates Member of the American Medical Association.

Corbus, Budd Clarke ✠ Evanston, Ill.; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1901; specialist certified by the American Board of Urology; member of the American Urological Association; fellow of the American College of Surgeons; at one time on the faculty of his alma mater; died Nov. 7, aged 78.

Crawford, Walter W. ✠ Hattiesburg, Miss.; Jefferson Medical College of Philadelphia, 1898; past president of the Mississippi State Board of Health; member of the Southern Surgical Association; fellow of the American College of Surgeons; died Nov. 2, aged 82.

Crow, Leonidas Hamilton, Athens, Ga.; Georgia College of Eclectic Medicine and Surgery, Atlanta, 1892; past president of the Clarke County Medical Society; for many years city and county physician; died Oct. 29, aged 84, of cerebral thrombosis.

Daggett, Earl Hampton ✠ Oakland, Calif.; Oakland College of Medicine and Surgery, 1909; died Sept. 4, aged 80, of intestinal carcinoma.

Davis, Carroll Augustus ✠ Logan, W. Va.; University of Maryland School of Medicine, Baltimore, 1909; past president of the Logan County Medical Society, of which he was secretary for six years; served on the staffs of Holden (W. Va.) Mercy Hospital and Logan General Hospital; died Oct. 26, aged 72, of nephrosclerosis and uremia.

Early, Clyde Emerson ✠ Los Angeles; Indiana University School of Medicine, Indianapolis, 1911; served during World War I; formerly medical director and owner of the Golden State Hospital, and on the staffs of the California and Cedar of Lebanon hospitals; died Oct. 14, aged 70, of chronic myocarditis and cerebral hemorrhage.

Easton, John Crockett, Springfield, Ohio; Miami Medical College, Cincinnati, 1901; member of the American Academy of Ophthalmology and Otolaryngology; served on the local medical examining board during World War I; on the staff of the Springfield City Hospital; died in the Mercy Hospital Sept. 30, aged 80, of bronchopneumonia.

Finkel, Louis, Boston; Middlesex College of Medicine and Surgery, Cambridge, Mass., 1930; died in Nantasket Beach, Mass., Sept. 3, aged 60.

Flader, Otto Fredrich ✠ St. Louis; St. Louis College of Physicians and Surgeons, 1904; an Associate Fellow of the American Medical Association; served during World War I; selective service examiner during World War II; died Oct. 5, aged 74, of heart disease.

Flynn, John Henry, St. Helens, Ore.; Ensworth Medical College, St. Joseph, Mo., 1897; served as county health officer; contract physician during the Philippine insurrection and was with the American contingent during the Boxer rebellion in China; served on the staff of the Good Samaritan Hospital in Portland, where he died Oct. 1, aged 83, of cerebral hemorrhage.

Ford, John Francis ✠ Boston; Dartmouth Medical School, Hanover, N. H., 1892; died Oct. 9, aged 84, of bronchopneumonia and arteriosclerosis.

Forsley, Thomas Jr. ✠ Billerica, Mass.; Tufts College Medical School, Boston, 1919; on the staff of Lowell (Mass.) General Hospital; died Oct. 4, aged 60, of coronary occlusion and cardiac infarction.

Fowkes, John Thomas, LaFargeville, N. Y.; Queen's University Faculty of Medicine, Kingston, Ontario, Canada, 1891; served the town of Orleans, Jefferson County, as a health officer for many years; on the associate staff, Good Samaritan and Mercy hospitals in Watertown; died Oct. 14, aged 87, of cerebral hemorrhage.

Friedrich, Martin ✠ Brooklyn; Long Island College Hospital, Brooklyn, 1925; specialist certified by the American Board of Internal Medicine; on the staff of the Jewish Hospital; medical director of the Gerald Friedrich Leukemia Research Foundation; died Oct. 18, aged 52, of coronary disease.

Garbutt, Victor L., Laguna Beach, Calif.; Michigan College of Medicine and Surgery, Detroit, 1900; died Sept. 23, aged 80, of ruptured abdominal aneurysm.

Greenschpoon, Joel O. ✠ Los Angeles; Long Island College Hospital, Brooklyn, 1914; died in Ocean Park, Calif., Sept. 29, aged 71, of acute ventricular failure.

Hahs, John Francis, La Center, Ky.; St. Louis College of Physicians and Surgeons, 1898; past president of the Ballard County Medical Society; served during World War I; for many years surgeon for the Illinois Central Railroad; died Oct. 20, aged 79, of coronary thrombosis.

Hughes, John Edward, Portland, Ore.; St. Louis University School of Medicine, 1925; served during World War II; physician and surgeon for the Southern Pacific Railroad and the Northern Pacific Terminal Company; died Oct. 15, aged 53, on the campus of the University of Notre Dame at South Bend, Ind.

Kemper, Arthur Thomson ✠ Muncie, Ind.; Medical College of Indiana, Indianapolis, 1897; since 1903 surgeon for the New York Central Railroad; on the staff of Ball Memorial Hospital; died Oct. 4, aged 84, of arteriosclerosis.

Kerr, Theodore Joseph ✠ North Platte, Neb.; University of Nebraska College of Medicine, Omaha, 1908; served during World War I; died in Pueblo, Colo., Sept. 8, aged 75, of hypersplenia and secondary anemia.

Kirby, George Wightman ✠ Wichita, Kan.; Rush Medical College, Chicago, 1905; served overseas during World War I; on the staff of St. Francis Hospital, where he died Oct. 27, aged 73, of cerebral thrombosis and diabetes mellitus.

Knappenberger, George Emmett ✠ Macomb, Ill.; Rush Medical College, Chicago, 1909; served during World War I; died Oct. 23, aged 70, of myocarditis.

Kurzrock, Julius, Nashville, Tenn.; Fordham University School of Medicine, New York, 1918; specialist certified by the American Board of Obstetrics and Gynecology; formerly clinical professor of gynecology and obstetrics at the New York Polyclinic Medical School and Hospital; died Oct. 14, aged 61, of coronary sclerosis.

McSheehy, Theobald Coleman ✠ Worcester, Mass.; Columbia University College of Physicians and Surgeons, New York, 1902; for many years on the staff of St. Vincent's Hospital; on the staffs of Worcester Hahnemann and Fairlawn hospitals; died Oct. 13, aged 79, of diabetes mellitus and arteriosclerosis.

Molitor, Nicholas ✠ San Diego, Calif.; Rush Medical College, Chicago, 1891; member of the American Urological Association; died Oct. 20, aged 84, of mesenteric thrombosis and arteriosclerosis.

Montgomery, Bruce B., Gatlinburg, Tenn. (licensed in Tennessee in 1905); veteran of the Spanish-American War; for many years member of the county school board; representative for Sevier County for three terms and a member of the Sevier County Court for six years; physician for the Little River Lumber Company for 22 years; died in Jefferson City Oct. 15, aged 84.

Nevitt, Philip Henry, Louisville, Ky.; Kentucky School of Medicine, Louisville, 1901; retired from the Veterans Administration Dec. 31, 1949, after serving for many years; died in St. Joseph Infirmary Oct. 28, aged 74, of coronary sclerosis and carcinoma of the bronchus with metastasis to the liver.

Newton, Henry Oscar ✠ La Plata, Mo.; Rush Medical College, Chicago, 1896; on the courtesy staff of the Woodland Hospital and Clinic in Moberly, where he died Oct. 11, aged 87, of arteriosclerotic heart disease.

Nieweg, George Alfred, Kansas City, Mo.; Bennett Medical College, Chicago, 1913; served on the staffs of various Veterans Administration hospitals; died Sept. 27, aged 63, of cerebral hemorrhage.

Nyman, Carl Victor ✠ Rockford, Ill.; George Washington University School of Medicine, Washington, D. C., 1903; also a graduate in pharmacy; on the staffs of the Swedish-American and St. Anthony hospitals; died Oct. 20, aged 82, of left ventricular heart failure.

O'Brien, David Daniel ✠ Oswego, N. Y.; Syracuse University College of Medicine, 1900; chief medical officer of Oswego Hospital for many years; died Nov. 7, aged 82, of heart failure.

Peterson, Carl Arnold, Carlsbad, Calif.; Barnes Medical College, St. Louis, 1905; formerly practiced in Moline, Ill., where he was in charge of the district health unit; died Oct. 30, aged 76.

Peyton, Harry Alexander ⊕ Jacksonville, Fla.; George Washington University School of Medicine, Washington, D. C., 1910; member of the Southern Surgical Association; fellow of the American College of Surgeons; specialist certified by the American Board of Surgery; served during World War I; for many years associated with the Riverside Hospital, where he died Oct. 17, aged 70, of coronary occlusion.

Ray, Alexander Hamilton, Winston-Salem, N. C.; Leonard Medical School, Raleigh, 1908; for many years physician at the Winston-Salem Teachers College; died in New York City Oct. 15, aged 70.

Remy, Sylvio Bernard ⊕ Webster, Mass.; Georgetown University School of Medicine, Washington, D. C., 1937; certified by the National Board of Medical Examiners; specialist certified by the American Board of Radiology; in World War II, served four years with the Army Medical Corps in the China, Burma, India theater; on the staff of the Webster District Hospital; died in Chicago Oct. 8, aged 44, of coronary thrombosis.

Ruggles, Charles Lounsbury, Cleveland; Western Reserve University School of Medicine, Cleveland, 1913; specialist certified by the American Board of Pediatrics; member of the American Academy of Pediatrics; senior clinical instructor in pediatrics at his alma mater; on the staffs of the University, St. Luke's, and Cleveland City hospitals; died in Cleveland Clinic Hospital Sept. 29, aged 66, of glioblastoma.

Schaefer, George W. ⊕ North Evans, N. Y.; University of Buffalo School of Medicine, 1901; died in Gowanda State Homeopathic Hospital in Helmuth, Aug. 16, aged 78, of coronary occlusion.

Schall, Reuben Elmer ⊕ Camden, N. J.; College of Physicians and Surgeons, Baltimore, 1904; on the courtesy staff of West Jersey Hospital; for many years associated with the Camden Home for Children; vice-president of the Bishop Bayley Building and Loan Association; died in Our Lady of Lourdes Hospital Oct. 14, aged 78, of carcinoma of the stomach.

Schwarzfeld, Howard Karl ⊕ Kearny, N. J.; Louisiana State University School of Medicine, New Orleans, 1940; served during World War II; later recalled to active duty; specialist certified by the American Board of Dermatology and Syphilology; died Oct. 17, aged 39, of leukemia.

Senn, Emil John ⊕ Schenectady, N. Y.; Albany (N. Y.) Medical College, 1911; formerly county coroner; for many years school physician; on the staffs of Ellis and St. Clare's hospitals; died Oct. 10, aged 71, of arteriosclerotic heart disease.

Sheifer, Saul, New York City; Long Island College Hospital, Brooklyn, 1911; served during World War I; died in the Manhattan General Hospital Oct. 22, aged 70, of a heart attack.

Sheitlis, Benjamin E. ⊕ New York City; Cornell University Medical College, New York, 1903; served as chief surgeon of the outpatient department of Beth Israel Hospital and as adjunct attending gynecologist and chief of the outpatient surgical department at the Sydenham Hospital; a founder and director of the American Jewish Physicians Committee; died in the New York Hospital Oct. 17, aged 73.

Shrader, John Clinton ⊕ Fort Dodge, Iowa; State University of Iowa College of Medicine, Iowa City, 1922; served during World War II; on the staffs of St. Joseph Mercy and Lutheran hospitals; died Sept. 10, aged 56, of coronary thrombosis.

Siman, Victor Lamont, Los Angeles; Chicago College of Medicine and Surgery, 1913; died in Veterans Administration Center in West Los Angeles Sept. 15, aged 63, of perforated esophagus, arteriosclerosis, and nephrosclerosis.

Skelly, Joseph John, York, Pa.; Temple University School of Medicine, Philadelphia, 1932; served during World War II; died Sept. 16, aged 46, of coronary occlusion.

Southall, Samuel A. ⊕ Lonoke, Ark.; University of Tennessee Medical Department, Nashville, 1892; first president and for many years a member of the state board of health; for many years county health officer and member of the anatomy board of the state board of embalmers; died Oct. 14, aged 87, of coronary heart disease.

Stokes, Thomas Henry ⊕ Pensacola, Fla.; Atlanta College of Physicians and Surgeons, 1912; on the staffs of the Baptist Hospital and the Sacred Heart Hospital, where he died Aug. 8, aged 65, of pulmonary edema and arteriosclerotic heart disease.

Taneyhill, George Lane, Baltimore; Johns Hopkins University School of Medicine, Baltimore, 1904; member of the American Psychoanalytic Association; member of the House of Delegates of the American Medical Association in 1907, 1908, 1909, 1912, and 1914; died in Springfield State Hospital in Sykesville, Md., Aug. 29, aged 74, of cerebral vascular accident.

Triplett, Thomas Arnold ⊕ Denver; Denver and Gross College of Medicine, 1905; died in the Veterans Administration Hospital Sept. 3, aged 79, of carcinoma of the bladder.

Ullery, Gustin Carleton ⊕ Springfield, Ohio; State College of Physicians and Surgeons, Indianapolis, 1907; specialist certified by the American Board of Surgery; served on the staff of the Springfield City Hospital and the courtesy staff of Mercy Hospital, where he died Oct. 30, aged 74, of bronchopneumonia.

Uniac, Thomas Vincent ⊕ Lawrence, Mass.; Dartmouth Medical School, Hanover, N. H., 1909; served as city physician; on the staff of the Lawrence General Hospital; died Oct. 8, aged 73, of coronary heart disease.

White, Eben Wesley, Seattle; George Washington University School of Medicine, Washington, D. C., 1907; served during the Spanish-American War and World War I; died in the Maynard Hospital Oct. 17, aged 86, of coronary thrombosis and nephrosclerosis.

Whitelaw, William R., Lodi, Wis.; University of Michigan Department of Medicine and Surgery, Ann Arbor, 1880; local health officer; died Aug. 26, aged 101, of senility.

Williams, Stephen E. ⊕ Chippewa Falls, Wis.; University of Minnesota College of Medicine and Surgery, Minneapolis, 1904; died Aug. 27, aged 76, of aortic stenosis.

DIED WHILE IN MILITARY SERVICE

Morgan, Clifford Veryl ⊕ Colonel, U. S. Army, Washington, D. C.; born in Elmwood, Neb., Dec. 18, 1901; University of Nebraska College of Medicine, Omaha, 1927; interned at the Walter Reed General Hospital; graduated from the Army Industrial College in 1940 and was chief, commodities division, Army-Navy Munitions Board, until early 1943; after attending the Command and General Staff College, was assigned as deputy general purchasing agent in the European Theater of Operations; in 1941 became commanding officer of the 809th Hospital Center in France; in 1945 returned to the United States and was assigned as executive officer of the Crile General Hospital in Cleveland; in 1946 was made deputy post commander of the Walter Reed Army Medical Center; from October, 1948, to July, 1952, was the deputy chief surgeon of the European Command with headquarters in Heidelberg, Germany; on returning to the United States in the summer of 1952 was made the inspector general of the Army Medical Service; appointed chairman of the Army Physical Review Council on March 1, 1954; awarded the Legion of Merit with Oak Leaf Cluster; the Bronze Star medal for establishing procurement offices in Belgium, Luxembourg, Switzerland, Spain, Portugal, and Sweden; the Army Commendation Ribbon; and the Croix de Guerre with Palm; named Officer, Order of the Oaken Wreath, Grand Duchy of Luxembourg; member of the American Association for the Advancement of Science, the Association of Military Surgeons of the United States, and the American College of Hospital Administrators; died in the Walter Reed Army Hospital Oct. 3, aged 52, of aortic stenosis.

FOREIGN LETTERS

ENGLAND

British Physicians in the U. S. S. R.—A party of 19 British physicians paid a short visit to Russia as the guests of the U. S. S. R. Ministry of Health. These included Dr. T. F. Fox, the editor of the *Lancet*, who has published his impressions of the visit (*Lancet* **2**:748, 803, 1954). He visited Moscow, Leningrad, and Georgia. Antenatal care in Russia includes a Wassermann reaction and a course of "psychoprophylaxis." Like men, women normally have paid jobs, and maternity leave begins about five weeks before delivery. Besides full pay, the woman gets a maternity grant of 1,500 rubles. Mothers with more than five children receive financial help, but otherwise grants are paid only to those who work. Mothers normally get up on the 4th postpartum day and do physical exercises daily from then until discharge on the 10th day. In the hospital, babies are separated from their mothers except at feeding time. Maternity mortality in 1953 was 0.8 per 1,000 births. Breast feeding is supplemented with solids at 3 or 4 months of age and continues until about 1 year. During the day the mother usually keeps her child in a crèche at her workplace, and every three hours she is allowed half an hour in which to feed him. Babies are still sometimes heavily swaddled, and some still have pacifiers to suck. Circumcision is not usually done. Vitamin preparations and supplementary foods must be bought if they are wanted, which perhaps explains why rickets has not yet disappeared.

In cities the care of children up to the age of 16 is undertaken by special children's polyclinics. One in Moscow, which cares for 27,000 children and has a staff of 62 physicians (27 district pediatricians, 14 school physicians and the remainder specialists of various kinds), was visited. It has no beds and is open only by day. As soon as the mother gets home she is visited by a district pediatrician and a nurse and is then expected to bring the child regularly for examination, at first twice a month and then less often. Great importance is attached to vacations. In 1952 over 5,500,000 children were sent to summer camps. BCG vaccination is performed at birth and repeated at 7, 12, 15, and 18 years of age.

One of the characteristic features of Soviet medicine is that they set great store by frequent examination as a means of recognizing disease early. For Moscow children there are obligatory examinations at the ages of 3 and 7 years. The Moscow University student has a searching examination (including x-ray screening) every year; Moscow adults are supposed to go to the polyclinics once or twice a year for an examination. There are also special mass examinations for detecting particular diseases. Small teams of specialists may invade a factory or district and examine everybody in it. Thus, in one year 27 million persons were examined for tuberculosis, and, since 1946, 60 million have been examined for cancer. Untreated cancer was found in 0.1% of those examined and a precancerous condition in 1%. The proportion of cancers incurable when first seen is said to be falling: 45% in 1946, 23% in 1950.

Every Soviet worker is supposed to get a month away from work every year and miners two months. One of the functions of the trade unions is to subsidize vacations and run rest houses and sanatoriums. The Sanatorium for Mine-Workers at Sochi on the Black Sea has 350 inmates, looked after by 18 physicians, 32 medical ancillaries, and 300 other workers, a ratio of 1 patient to 1 worker. At some 250 health resorts, with 2,000 sanatoriums, about 4 million persons were treated in 1953. There are 13 research institutes devoted to the problems of health resorts and natural spas.

As for the hospitals, alike in the consulting room of a polyclinic, in the electrocardiography department of a sanatorium, and in the ward corridor of a hospital, the Russians commonly manage to avoid the institutional outpatient atmosphere too often associated with our own medical installations. They do it by using climbing green plants in pots, ornamental but washable curtains, photographs of children, and by not acquiring a hospital manner. On the other hand, from the moment of arrival the patient is made aware of the necessity of asepsis. As in some other countries, for example, the blood donor lies on a couch in one room and puts his arm through a hole into another room where the blood is drawn, but before a Russian donor is laid on the couch he is given a shower, attired in gown and mask, and exposed to ultraviolet rays on his way upstairs. All the hospitals visited were very clean. In contrast their lavatories were sometimes unacceptable by British standards. The Russian hospital may be better than some of ours for the patient who mainly needs sympathetic care and long-established treatment, but it does not offer an equal chance to the patient whose survival depends on one of the newer techniques, such as the maintenance of fluid and electrolyte balance, the use of endocrine preparations, or treatment with the more recent antibiotics. Local anesthesia is so widely used that procaine injections suffice for a pneumonectomy, creating an artificial esophagus, or removing an intracranial tumor.

There are some 300,000 physicians in the U. S. S. R. (compared with 20,000 in Tzarist Russia). Although more than half are women, the senior posts are usually held by men. The civilian physician is exempt from military service (except in time of war), but the newly qualified are likely to be sent for several years to some outlying part of the Soviet Union where few would spontaneously choose to practice. In the Soviet Union the physician is a public servant whose primary loyalty is to the state, not the patient. He does not regard himself as an individual practitioner, assuming full charge of his patient and exercising full responsibility, but rather as a member of a service. He does not practice from his private house but from a medical station, dispensary, polyclinic, or hospital, which is the local outpost of the service and where he is one of a medical team. He may or may not be interested in the whole household and its affairs, but he is certainly not a family physician, for he undertakes no obstetrics and is not concerned with the children, who are looked after by pediatricians from the children's polyclinic. Moreover, before long he may move on to another place or become a specialist. Dr. Fox asked whether patients take their nonmedical troubles to their physician, for example, whether a woman would consult him because her husband drank? "What would be the good of that?" was the reply. She would go to the authorities at the place where her husband worked or to the trade union. In matters of character or worries, how could a physician help? No difference between British and Russian practice was more noticeable than the apparent disinclination of the Russians to accept emotional disturbance as a cause of illness. Whereas any British patient today is lucky if he escapes a diagnosis of functional disorder, or at least of a psychological overlay, neuroses and psychoneuroses figure very little in the Russian clinical vocabulary. The bottle-of-medicine habit must also be far less prevalent, for the Soviet medical service is far less generous than ours, in that the patient has to pay for all drugs beyond those consumed on medical premises. If he needs medicine at home he is given a prescription to be made up by a pharmacy at his own expense. If he really cannot pay he must apply for assistance.

The basic salary of the young physician is 660 rubles a month. The director of a polyclinic with a medical staff of 45 was getting 1,750 rubles, and the district physicians 1,250 (a miner gets 2,000 rubles). Salaries rise by seniority, and there are also merit awards. In the academic sphere salaries rise sharply. Thus, a physician who is the director of a medical institute and also chief of a professorial department will receive 11,500 rubles a month.

In Tzarist Russia there were 13 university faculties of medicine, and five medical schools for women, with an annual output of 1,500 physicians qualified after five years' training. There are now 63 medical schools (all under the aegis of the Ministry of

The items in these letters are contributed by regular correspondents in the various foreign countries.

Health) and the output is 20,000 to 25,000 physicians annually. The acceptance rate for training is 1 in 9, and the usual starting age is 17. Students are paid a stipend of 220 to 290 rubles a month. The course lasts six years, and all examinations are oral. The only special development in medical education is the addition to medical school staffs of a professor of Marxism and Leninism. The failure rate is low, as the students are well disciplined and work well, Dr. Fox was told.

There are 279 institutions for medical research in the U. S. S. R. Some of these are well equipped, and their staffs are of high quality, but they will not be able to play their full part in the development of medicine until they are able to work without looking over their shoulders. The very essence of science is that facts are facts, whoever discovers them, and Russian investigators will remain under a grave handicap so long as those who accept Western discoveries or ideas know that they are liable to censure as lackeys of bourgeois science or worse. The Soviet Union will sooner or later have to choose between science and chauvinism. On the other hand, there are signs that the group now leading the Soviet Union understand that, no matter how much money is spent on science, it will never really flourish except in a scientific atmosphere, an atmosphere in which scientists are able to think and speak for themselves, initiate and plan for themselves, and criticize and be criticized without losing their jobs.

Medical Litigation.—According to the annual report of the Medical Defense Union, an organization established 70 years ago to advise and assist its members in cases of alleged negligence, there is no abatement of the flood of medical litigation, nor is there any evidence of a reduction in the large sums awarded as damages. Sums of a similar order are paid on behalf of practitioners in the settlement of cases out of court, when the action, or inaction, of the practitioner is indefensible. In a high percentage of actions brought against practitioners (some have placed it at 80%) the plaintiff is legally assisted at the expense of the state. To secure this benefit the plaintiff, through his solicitors, must obtain a legal aid certificate from a local committee specially appointed for that purpose. This committee determines whether there is a prima facie case for the courts. The plaintiff is not always successful, but the union has little or no hope of recovering any costs incurred in defending its member against allegations that have been proved to be groundless. In two cases undertaken by the union hearings extended over 11 and 13 days, respectively, one proceeded to the Court of Appeal, and, in both, judgments were returned in favor of the physician. The sums expended by the union in defending its members were $21,560 and $7,280, respectively, none of which is recoverable from the plaintiffs, who were legally assisted persons.

Discussions are proceeding in certain quarters on the equity of the arrangements that exist for the assistance of plaintiffs in pursuing a claim for negligence, and proposals are being examined that, if adopted, would impose on a plaintiff liability for payment of the costs of the defendant or defendants when the latter is successful. Whether, in the future, political and economic considerations will permit of this development or some other modification of the scheme remains to be seen, but, generally speaking, there is abroad a conviction that the legal aid scheme operates unfairly against successful defendants. In a recent judgment, Mr. Justice Stable said: "This man is legally-aided and his contribution for his own costs is assessed as nil. It is no good making any order for costs against him. I shall go on protesting against this system under which the State subsidizes litigants and then does not pay the costs of the other side when the assisted person loses. I have protested before but nobody listens and nobody, I suppose, ever will." The idea seems to be gaining ground among patients that the hospital is to be regarded as guaranteeing a cure. If a patient leaves a hospital worse than when he arrived he feels he is entitled to compensation. This view is seldom justifiable. Judges and physicians alike should take what opportunities arise to make it crystal clear that every untoward incident or accident arising in medical practice, inside or outside a hospital, is not necessarily due to negligence.

Inspection of General Practitioners' Offices.—In the fall of 1953 the chairman of the general service committee of the British Medical Association addressed a letter to every general practitioner, drawing attention to the necessity of maintaining a high standard in their office accommodations and making such improvements as were needed. The Minister of Health has been under continuous pressure to carry out an inspection of general practitioners' offices. In order to avoid this being done by executive councils (mainly lay persons), the general medical services committee obtained consent for this inspection to be carried out by local medical committees. A letter has now been sent on behalf of the committee to the secretaries of all local medical committees, asking them to undertake a survey of all general practitioners' offices in their area and to present a report within six months. The procedure recommended is that already put into force by the Birmingham local medical committee, of which the following outline has been published in the *British Medical Journal* ([Supp.] **2**:132 [Oct. 2] 1954).

All practitioners on the list of the Birmingham executive council were notified of the intention of the local medical committee to inspect physicians' offices. Physicians who were unwilling to receive "visitors" from the local medical committee were warned that such a refusal would entail official reference to the executive council. All members of the local medical committee took part in this inspection, working in pairs. The city was divided into sectors, and visitors from sector 1 inspected offices in sector 3, those from sector 2 visited offices in sector 4, and so on. Where it was found that the accommodation and/or equipment was unsatisfactory the physician was advised to make the necessary improvements and was then revisited after a reasonable period to make sure that he had complied. If he had not, he was warned that repeated refusal to make the necessary improvements would result in reporting his case to the executive council for official action.

Pharmaceutical Production.—In the inaugural address to the 113th session of the school of pharmacy of the University of London, Dr. H. Hepworth, D.Sc., who has just retired from the managing directorship of Imperial Chemical (Pharmaceuticals) Ltd., said that chemotherapy is far from being an exact science. Perhaps one in a thousand new chemicals survives elementary biological trials, and then one in five survives trials in larger animals. After a vast amount of time and money has been spent on a drug it may prove to be of no value in man. If the British pharmaceutical industry makes one really major discovery every five years it is doing well. It is greatly to the credit of some of the firms in this country that they have spent and are continuing to spend large sums on one or two particularly urgent problems, the solution of which would not bring a great deal of monetary reward. This country now has several well-equipped pharmaceutical research laboratories in industry, well-staffed with first class men who are choosing their targets wisely and are collaborating with many people in academic circles. This program must not be imperilled by too rigid a selling value system.

The value of the pharmaceutical production in Britain has risen from about 53 million dollars in 1935 to 322 million dollars last year. British pharmaceutical exports have increased nearly tenfold in that period, and about 50,000 people are now employed in the industry. About one-third of the production goes overseas, another third to the National Health Service, and the remainder is sold over the counter in this country. About 54% by value of the drugs now used were unknown a generation ago, and 80% of present-day prescriptions could not have been filled at that time. The main advances have been in antibiotics, sulfonamides, drugs for the treatment of tropical diseases, and vitamins. The export value of antibiotics is greater than that of all drugs put together a generation ago.

Conference on Cerebral Palsy.—A three day conference on the treatment of cerebral palsy, organized by the British Council for the Welfare of Spastics, was held in London. Americans participating in the meetings included Drs. Winthrop Phelps of Maryland, Temple Fay of Philadelphia, and M. A. Perlstein, president of the American Academy for Cerebral Palsy. Mr.

Wylie McKissock, surgeon to the National Hospital for Nervous Diseases, Queen's Square, reported on his results in 35 patients with hemiplegia, in whom he had performed complete hemispherectomy during the last five years. His criteria for operation were: hemiplegia from early infancy, associated with epilepsy uncontrolled by drugs; severe temper tantrums; and a mild degree of mental retardation. Operation can be performed at any age after the first year. The results were satisfactory so far as epilepsy and temper tantrums were concerned, but the hemiplegia was little affected, except possibly for some diminution in spasticity. Dr. Karel Bobath gave details of his method of treatment based on inhibiting overactive tonic reflexes, which lead to deformities and should therefore be stopped early. This was done by holding the patient in a reflex inhibitory posture until he got used to it. Following such a procedure, muscle tone improved, breathing and speaking benefited, and in time the child learned to hold the correct postures for longer and longer periods, until finally the incorrect postures disappeared. The child could then be taught how to perform new muscle movements.

Antioxidants in Food.—The Food Standards Committee of the Ministry of Food has issued a report recommending that antioxidants should not be added to any foods other than to edible oils and fats, i. e., animal, vegetable, and fish oils, whether hardened or not, vitamin oils and concentrates, and products consisting essentially of fat such as margarine or shredded suet but not including butter, and to essential oils, including their flavoring constituents, isolates and concentrates, but not flavoring essences. They recommend that official approval should be restricted to propyl gallate, octyl gallate, dodecyl gallate, and butylated hydroxyanisole and that specifications as to the purity of these antioxidants should be prescribed. These substances may be added to edible oils and fats and to essential oils in quantities not exceeding:

Antioxidant	Edible Oils and Fats, %	Essential Oils, %
Propyl, octyl, or dodecyl gallate, or any mixture thereof	0.01	0.1
Butylated hydroxyanisole	0.02	0.1

Butylated hydroxyanisole, up to 0.02%, may be used in conjunction with the gallates, up to 0.01%, in edible oils and fats, but in the case of essential oils the total amount of antioxidant or mixture of antioxidants should not exceed 0.1%. The committee does not consider it necessary or desirable to extend the use of antioxidants to any other classes of foods. It was advised that these recommendations be reviewed after a period of two years.

ITALY

Assembly of World Medical Association.—The World Medical Association held its annual meeting in Rome from Sept. 26 to Oct. 2 under the presidency of Prof. Antonino Spinelli. More than 1,000 physicians from 50 nations, representing a total of more than 700,000 physicians, attended the meeting. Dr. Dag Knutson of Sweden submitted the annual report of the executive council. One of the problems discussed was the large number of physicians in some countries and the scarcity in others. This problem will have to be solved by each nation, because physicians are not industrial products that can be shifted from one country to the other without regard to their personality, customs, and habits. The highest proportion of physicians is found in Austria (17 per 10,000 population), Germany follows with 15, Switzerland with 14, and the United States with 13.3. The lowest proportion is found in Ireland (6.7), Sweden (6.6), and France (8.1). With regard to the protection of civilian physicians and civilian medical units in the event of war, the council recommended the adoption of a special international emblem, because the Red Cross emblem, according to present laws, cannot be used by civilians. The proposal was approved by the assembly.

Dr. Cibrie of France said that the principle of social insurance is, as a rule, accepted by the physicians who also recognize the necessity of a close cooperation of the physicians with the insuring bodies. This cooperation, however, must be based on certain fundamental principles. Some insuring bodies tend to consider the physicians whose services they use as their employees. This concept is not admissible, nor is it justified, and therefore it must be corrected. In 1952 and again this year a questionnaire was sent to the 19 nations who are members of the World Medical Association. Thirteen countries replied. All agreed that the physicians are involved in incessant disagreements and continuous arguments with the insuring bodies because these bodies tend to modify the basic principles of the practice of medicine. All the countries were in favor of free assistance to the poor but declared that it is not desirable to extend social insurance to the entire population, and all were opposed to turning the physicians into state functionaries. In almost all the replying countries a public tendency to seek help directly from the specialist has been noted. Thus the important role of the family physician has lost much of its former prestige. A source of great concern is the problem of taxes as they are applied to physicians. This problem must also be solved by each nation individually. In discussing the report Professor Costa of Chile stated that in his country all the physicians are government functionaries. They work a maximum of six hours a day for the state and are free to use the remaining time for their private practice. He believes that this situation is incompatible with good professional service.

Dr. Austin Smith of the United States reported on the official publication of the association, the *World Medical Journal*, which is still in a developmental stage. The main aim of this publication is to make known the work that has been done in various fields. Every effort is made to publish material that is both interesting and useful. Dr. Cibrie reported on the necessity of compiling a restatement of the main principles of medical ethics in keeping with modern times. The committee on medical ethics must make each precept as concise and as clear as possible, so that it may be translated into all languages, leaving it up to each nation's professional organizations to work out details for the enforcement in accordance with the laws and customs of the country. As far back as 1949 the World Medical Association formulated an international code of medical ethics. Dr. Cibrie submitted to the assembly the text of a chapter on the physician's duty to society. After some amendments by the various delegates and a reexamination of it by the council, the chapter will be added to the 1949 code. The question of the relationship between medical and lay writing was discussed, and the hope was expressed that an understanding might be reached between the medical world and the press, so that writings dealing with medical and scientific matters would be assigned to persons with special training in this field.

Problems of Cardiology.—Drs. Boccardelli and Boldrini used the hypoxemia test in an attempt to diagnose the presence of chronic coronary insufficiency in patients who did not have clinical signs of angina pectoris. The diagnostic validity of such a test in coronary insufficiency is evaluated differently by various authors. Technical modifications in its application have been introduced recently to make it more sensitive. Instead of having the patients inhale a 10% mixture of oxygen in air, as is usually done, Penneys and Thomas had them reinhale their own expired air. They controlled the oxygen saturation level oxymetrically and attributed the various modifications in the function of the cardiovascular system to the varying degree of oxygen saturation. Mathers and Levy had their patients inhale a 10% mixture of oxygen in air, but with oxymetric control, and observed that the degree of hypoxemia obtained varied widely in different persons.

Drs. Boccardelli and Boldrini, on the other hand, after extensive clinical observation of normal persons, made use of the hypoxemia test and had the patients inhale a 7% mixture of oxygen in air. They reported the results of these experiments at the meeting of the Italian Society of Cardiology in Rome in April. Thirty patients between 50 and 64 years of age were examined. On the basis of clinical, radiological, and electrocardiographic signs, an arteriosclerotic cardiopathy could be assumed to be present in these patients even though they had no pain. Breathing the 7% mixture of oxygen in air was continued for 10 minutes, and electrocardiograms were taken before

and 5 and 10 minutes after the test. There were no marked disturbances. The test was discontinued in seven patients who complained of a slight sense of precordial pain. In two patients the electrocardiogram revealed that the test was already abnormal at the fifth minute. The test gave an abnormal result in 40% of the patients. The speakers found that these results paralleled those obtained with the test of effort. This valuable diagnostic test is easy to apply.

Fibroma and Cancer of the Uterus.—At a meeting of the medico-surgical society of Pavia in March, Professor Pezzini stated that fibroma and cancer of the body of the uterus are so often associated that the coexistence of the two neoplasms cannot be accidental. In an attempt to individualize some of the conditioning factors in the genital system, the ovary and the endometrium of women with fibroma of the uterus and/or cancer of the body of the uterus were studied. This study revealed the presence of such correlated alterations of the ovary and the endometrium as sclerocystic degeneration of the ovary, simple and cystic hyperplasia of the lymph nodes of the endometrium, and persistence of the proliferative phase beyond the third week of the menstrual cycle. These correlated alterations were found quite often in women with fibroma and/or cancer of the body of the uterus. Because the abnormal persistence of the estrogenic secretion or a relative excess of it is believed to be the cause of the above-mentioned aspects of the endometrium, earlier investigators suspected that such endocrine factors predispose to the production of fibroma and cancer of the body of the uterus. Professor Pezzini advanced the hypothesis that among the factors predisposing to these conditions there is also an excess of folliculin. This can be an excess of quantity or of persistence in time.

Antidiphtheria Revaccination.—At a meeting of the medico-surgical society of La Spezia, Professor Vezzoso said that difficulties are met in the immunization of school children against diphtheria by means of injections. This procedure alarms the families. A "vaccination plaster" called "Difto percutan," which is prepared by the Siena Istituto Sieroterapico Sclavo, was used experimentally in the province of La Spezia on a group of 110 children who had a positive Schick test. In children who had been given an immunizing injection of toxoid less than a year earlier the Schick test became negative 15 to 20 days after the application of the plaster.

MEXICO

Recent Advances in Angiocardiography.—Dr. Antonio Rodríguez-Alvarez of the Instituto Nacional de Cardiología de México has analyzed several hemodynamic and physical principles underlying the injection of radiopaque substances in the cardiovascular system. From these studies it was concluded that the needs of modern selective angiocardiography could be fulfilled by a machine that could inject the radiopaque substances through long, narrow cardiac catheters, as has been done by the Swedish investigators. Drs. Rodríguez-Alvarez and Narno Dorbecker have devised and constructed a machine that will inject radiopaque substances during the length of time necessary to obtain the desired contrast with maximal safety to the patient. This has been achieved with enormous injecting pressures that produce high velocity of the fluid at the tip of the catheter. Dr. Alvarez has developed a special tip that prevents both the recession of the catheter resulting from this high velocity and the possibility of producing extrasystoles or more serious arrhythmias when injecting near the interventricular or interatrial septums. The authors have applied their machine to thoracic aortographies and selective angiocardiographies and have obtained excellent results, both in contrast and in selectivity. The machine is so devised that there is no danger of injecting air bubbles. It uses compressed air as a source of energy and has a mechanism for the automatic synchronous starting of the seriographs and the injection.

PERU

Electrolytic Balance and Adrenal and Renal Functions in Pregnancy.—Dr. A. L. Grimberg of Lima studied 42 pregnant women, of whom 15 were normal, 11 were preeclamptic, 14 eclamptic, and 2 hypertensive, and concluded that tests of adrenal function in pregnant women show that during pregnancy a status comparable to the resistance period of the general adaptation syndrome develops. The toxemias of pregnancy may be considered as adaptation diseases produced by a stress factor arising in the placental-fetus complex. Treatment with ganglioplegics does not greatly modify the physiological effects that are produced on the hypophysoadrenorenal axis in the pregnant women. In all normal pregnant women there is a mild state of adrenal hyperfunction. Differential blood cell counts show a decrease in circulating eosinophils. In the toxemic women, on the other hand, there is a marked adrenal hyperfunction as reflected in an almost total lack of circulating eosinophils. In women of both groups there is good adrenal response to hypophyseal stimulation as shown by normal results of the Thorn test.

In normal pregnant women the glomerular filtration volume, judging by the creatinine clearance test, seems to increase as the pregnancy progresses as long as there is no change in renal tubular excretion and concentration. On the other hand, in the eclamptic women the renal function tests show a diminution in the filtered glomerular volume and disturbance in the tubular functions. There is usually a return to normal function during the puerperium. The lesser glomerular filtration volume may be due to a diffuse swelling of the basal layer of the glomerular capillaries and to a spasm of the afferent arterioles. The serum electrolyte levels in normal pregnant women show no significant change, despite a tendency to an increase in the plasma sodium concentration as the pregnancy progresses. In the eclamptic women the serum sodium level decreases and the serum potassium level increases.

Trephination by the Incas.—Eight hundred years ago the Incas performed skull trephinations as a therapeutic procedure, according to Dr. Francisco Graña, who spoke to the Peruvian Society of Neuropsychiatry in November. When the first trephined skulls were found about 50 years ago it was believed that they were the result of wounds inflicted to cause death. Further investigation on these skulls, however, showed circular bony scars indicating that such subjects had survived the injury. Several of these skulls were examined in the United States and France, and all examiners agreed that the skulls showed signs of bone repair. Dozens of such trephined skulls were found in the ruins of old Peruvian towns. With them, surgical instruments of a type used in this operation were also found. In order to control hemorrhage they seem to have used a ring-like ligature around the skull. Forceps of a type that could be applied to bleeding vessels were also found. There is evidence that an alcoholic beverage was used as a general anesthetic and a solution made from coca leaves as a local anesthetic. There is also evidence that they boiled their surgical instruments in containers with antiseptic herbs. Drs. E. Rocca, F. Graña, and L. Graña tested their conclusions by trephining a patient with a left subdural hematoma with the instruments employed by the Incas, which were borrowed from the Peruvian Government.

Poliomyelitis.—In Lima poliomyelitis attacks mainly the well-nourished children. Epidemiological studies carried out on this disease by Dr. H. Landázuri (*Revista peruana de neuro-psiquiatría*, vol. 17, no. 1, March, 1954) show that the poliomyelitis incidence and death rate in Lima are low and have not increased in the decade 1942 to 1951, being similar to those found in other capitals of South America. In the period studied, 726 cases of poliomyelitis were diagnosed, 90% of which occurred in children from 2 months to 4 years of age, 6.5% in children between 5 and 9, and the remainder in patients over 9 years of age. There is a greater predominance of this illness in children from 1 to 2 years of age than in those from 2 to 4. Children over 5 years of age are rarely attacked. The youngest patient was a 2-month-old baby. The death rate was about 0.5% in the children and 16.6% in the adults. More than half of these deaths occurred at home. The author attributes the low death rate to the high resistance of the host and not to any lack of

virulence of the virus. The average age of patients with this disease does not appear to be increasing as it is in countries where the morbidity and mortality rates are higher.

SPAIN

Blanco Soler Prizes Awarded.—The Association of Medical Writers and Artists recently awarded the Dr. Blanco Soler prizes for 1954. Twenty-four articles were entered in the competition. A first prize of 5,000 pesetas and a certificate of membership was awarded to Dr. Leopolod Cortejoso of Valladolid for his article "The Poet and His Secret: Psychology of Romantic Poetry." The second prize of 2,500 pesetas and a certificate of membership went to Dr. Luis del Campo Jesus of Pamplona for his article "Fragments of History and Medicine on the Life of Sancho, the Strong Man of Navarra." Among those receiving honorable mention and a certificate of corresponding membership was Dr. Julius Buscher of St. Cloud, Minn. The 1955 prizes will be awarded for the best articles on art, history, literature, and philosophy in their relation to medicine. The selection of subject, length of the article, and number of illustrations included in the article will be at the discretion of the author. Articles to be entered in the competition should be sent to Dr. Juan Fernán Pérez, General Secretary, calle Fuencarral, 113, Madrid, Spain. They should be sent in duplicate, distinguished by a motto, and accompanied in a separate envelope by the name of the author and the motto used, before April 30, 1955. The association retains the right to publish the articles of the authors who win the awards.

International Conference on Tuberculosis.—At the meeting of International Conference on Tuberculosis held in Madrid, Generalissimo Franco welcomed the delegates and decorated Drs. Waksmann, Domagk, Lehman, and Abreu with the Gran Cruz de Sanidad.

SWEDEN

Hyperparathyroidism.—In a series of 56 patients with hyperparathyroidism reported between 1930 and 1954 by Dr. John Hellström of Stockholm, 37 were discovered since 1950, whereas during the period 1930 to 1949 only one or two such patients were observed every year (*Nord. med.* [Oct. 14] 1954). The tendency to overlook this disease is also shown by the fact that, in this series, an average of eight years elapsed between the first appearance of symptoms and the correct diagnosis. This delay reflects the often vague character of the symptoms and their liability to be attributed to some other disease. There were twice as many women as men in this series, and their ages varied greatly, the youngest being only 16 and the oldest 62 years of age. In 13 patients radiologically demonstrable skeletal changes were the chief guide to the diagnosis; in 11 there was evidence of skeletal changes and of renal disease; and in 32 the manifestations of hyperparathyroidism were confined to the urinary tract. In 21 patients 34 operations had been performed for calculi in the urinary tract before the true character of the disease was recognized; one of these patients had had 5 such operations. In 44 patients the morphological basis of the hyperparathyroidism was an adenomatous enlargement of one parathyroid gland only. Coexistant changes in the parathyroid and thyroid glands were found in 22 patients, and in 2 there was concomitant severe hyperparathyroidism and hyperthyroidism. The demonstration of hypercalcemia is of paramount importance to the diagnosis of hyperparathyroidism, although it may exist even when the serum calcium level is only slightly raised. The results of the radiological treatment of this disease were uniformly discouraging. The only rational treatment is the radical removal of hyperactive parathyroid tissue. When an adenoma is solitary, the immediate results of parathyroidectomy are usually good, and even incomplete removal of parathyroid tissue may give marked and prolonged improvement. Treatment should be started as soon as possible, because the prognosis largely depends on the degree of damage to the kidneys. Left to itself the disease tends to progress, but spontaneous recovery is possible.

Cardiac Infarction.—Dr. G. Aspenström, in a recent study of postmortem findings at the Sahlgrenska Hospital in Gothenburg, has shown that many infarctions of the heart escape recognition during life (*Nord. med.* **52**:1263-1266 [Sept. 9] 1954). Between 1949 and 1953 he found that 197 patients coming to autopsy showed postmortem evidence of recent and/or old cardiac infarcts. In the same period 631 patients died in this hospital, and only 42 of them (6.6%) were not examined postmortem. Of the 138 cases of recent infarct, 27 were overlooked during life. It is probable that the tendency of painless infarcts to develop in diabetes may help to explain why infarction is so often overlooked. Of the 10 diabetics whose infarcts were overlooked, the infarct ran a painless course in 5. It would also seem that women are more subject than men to painless infarction, which is comparatively common in older persons, particularly when the brain has deteriorated. Hypertrophy of the heart with faulty compensation seems also to be associated rather frequently with painless infarction. The chief cause of failure to diagnose infarction seems to be the absence of characteristic pain and of electrocardiographic signs. Infarction is apt to be mistaken for an infectious disease when a patient is admitted to hospital with fever, leukocytosis, and a high sedimentation rate. In such patients dyspnea may be a useful guide, and in this series dyspnea was commoner than pain. The number of missed diagnoses might be reduced by better and more systematic electrocardiographic examinations and by avoiding the pitfall of demanding a sterotyped clinical picture including such features as pain, which are so often absent.

Death of Professor Key.—Prof. Einar Key, who died on Aug. 11, 1954, was born on Dec. 14, 1872, the son of Prof. Axel Key, the noted anatomist and pathologist, and rector of the Karolinska Institute. The son qualified as a physician at Uppsala in 1897 and in 1909 began his service at the Maria Hospital, where he was put in charge in 1911. He remained at the head of this hospital till he retired in 1937. His doctoral thesis in 1907 dealt with the surgical treatment of gastric ulcer, a subject in which he was personally interested, being a victim of this disease at that time. His earlier interest in diseases of the eye was followed by special studies of the urogenital tract, in which field he made important surgical contributions. Working with Jacobaeus he did much to advance the surgery of the lungs, and in 1930 he presented a report on 190 patients treated by thoracoplasty. He was also a pioneer in the operative treatment of embolism of the arteries of the limbs. He inherited from his father the editorship of *Acta chirurgica scandinavica*, a financial burden that he bore during the 32 years he was editor. He was an honorary member of the American College of Surgeons and the Royal College of Surgeons. In August, 1950, a small nodule in his right breast was shown to be adenocarcinomatous. A radical operation included removal of glands in the axilla, in which no metastases were found. No signs of malignant disease appeared till April, 1954, and he began to suffer from progressive lassitude. Postmortem examination showed metastases in spine and liver.

Smallpox Vaccination.—The experience of Dr. Björner Sjöberg with smallpox vaccination in Korea has convinced him that the scarification method of smallpox vaccination heretofore practiced in Sweden is inferior to the multiple pressure method practiced by the Americans in Pusan (*Svenska läk.* [Sept. 17] 1954). In May, 1953, Sjöberg relied so confidently on the smallpox vaccination he had undergone in Sweden that he did not hesitate to come into close contact with smallpox patients while studying the effects of a new chemotherapeutic agent, but he and two of his compatriots contracted smallpox, though their last vaccination in Sweden against it was at most two months old. In none of the three had earlier vaccination left any scarring, so it is possible the vaccination had never been really effective. Sjöberg endorses the American teaching that vaccination should be repeated till it has provoked an acceptable reaction. He is also in favor of revaccination at not more than half-yearly intervals when necessary. On his return to Sweden he carried out comparative tests of the two methods of vaccination on recruits. Alternate recruits were vaccinated by the scarification and multiple pressure methods, the same vaccine being employed in both. Of 227 recruits vaccinated by scarification 169 or 74.5% showed a positive reaction, whereas of 239 vaccinated by multiple pressure 232 or 97.1% showed a positive reaction.

CORRESPONDENCE

ASTHMA AND ARSENIC

To the Editor:—During the past few years there have appeared in medical publications several articles pertaining to the use and dangers of arsenic in the treatment of bronchial asthma. Although the subject matter merits constructive criticism, in several instances alleged prescriptions of the "Gay treatment" were published that were false, dangerous, and misleading. It is apparent that the authors of these articles failed to validate their factual material. In THE JOURNAL of March 1, 1952, page 734, there was published an article entitled "Cutaneous Sequelae Following Treatment of Bronchial Asthma with Inorganic Arsenic." In the description of case 2 a prescription was quoted in such a way as to imply that the said prescription was essentially the Gay formula. This prescription called for three times the amount of potassium arsenite (Fowler's) solution ever recommended by me or any of the physicians trained by me. In THE JOURNAL of Aug. 29, 1953, page 1711, an article was published entitled "Hemorrhagic Encephalopathy During Arsenic Therapy for Asthma." Although it was not specifically stated that this patient was treated by me or one of my former associates, there was an obvious inference to that effect. In this article it was stated categorically that analysis of the medicament at a well-known clinic revealed concentrations equivalent to 5 gm. of arsenic per liter. I wish to state most emphatically that this represents over 11 times the amount of arsenic ever used or advocated by me. It is obvious that this is a dangerous mixture, and it was evidently prepared by someone completely ignorant of the dangers of arsenic therapy or by someone attempting to discredit this form of treatment by misrepresentation.

It is in the public interest to have all controversial data carefully checked before publication. This holds true particularly in scientific articles in which the use or abuse of potentially toxic drugs is discussed. Although I have had excellent results in following the Gay treatment, others who have not had extensive experience may run into apparently insurmountable difficulties. Although I have encountered an occasional arsenical reaction, it has not constituted a serious threat to the merit of this treatment because of its early recognition and resultant modification of procedure. Since a positive approach to this matter is required, I am preparing a detailed account of the procedures involved in the Gay treatment and making a statistical survey of 1,000 cases that may be of considerable interest to all physicians engaged in this work.

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DRY CELL BATTERY EXPLOSION

To the Editor:—The experience of Dr. Richard Hewitt with hearing aid batteries, as reported in the Nov. 6, 1954, issue of THE JOURNAL, page 1010, was of interest to me. A few years ago a woman was brought to me with a lacerated wound of her left arm and forearm and also a burn. On inquiry as to the cause of the injury she informed me that, in preparing a fire outdoors, she had raked up trash, leaves, and bits of wood from the back yard as fuel. She noticed an old "dry cell battery" in the accumulation but thought nothing of it. When the fire was started and much heat generated, there occurred a terrific explosion that knocked her off balance and inflicted the severe wound. The battery was completely demolished. The battery described was of an ordinary flashlight size. I wonder what would happen if a large dry cell battery were subjected to the same condition? I agree with Dr. Richard Hewitt it would be wise for all dry cell battery manufacturers to label their products "Keep away from fire."

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TUBERCULOSIS SPECIALISTS ALERTED

To the Editor:—Earl Kill Smith (aliases: Earl James Smith Jr., Earl Smith, and Kill Smith), aged 25, was indicted by a federal grand jury at Baltimore Aug. 18, 1954, for bank robbery. He is also wanted for bank robbery at Philadelphia and is well supplied with funds. Information has been developed that as of March, 1951, he had positive and contagious pulmonary tuberculosis with right lung collapsed. It is indicated that this lung must be filled with air regularly and that he may, therefore, seek treatment from physicians who specialize in the treatment of tuberculosis. Smith is described as follows (see photograph): A Negro man, height 6 ft. 2 in., weight 190 lb., brown eyes, black hair, dark brown complexion, born July 11, 1929, in New York City. He sometimes wears a pencil mustache, dresses in sports clothes, and sometimes wears a beret. He reportedly is feminine in manner, uses large words and gives the impression of being well educated, has studied art, and is interested in

Earl Kill Smith. Left and center: date of photographs unknown. Right: photograph taken in 1950 or 1951.

poetry. He is known to have expensive tastes. Medical history: Smith has tuberculosis, in 1951 had the right lung collapsed, and may require pneumothorax injections.

Persons who receive any information concerning this man should communicate with the office of the Federal Bureau of Investigation, U. S. Department of Justice, Washington, D. C., the telephone numbers of whose local offices are listed on the first page of the local telephone directory. CAUTION: Smith is known to be armed and should be considered extremely dangerous.

SURGEON AND ANESTHETIST—GOOD AND BAD TEAMWORK

To the Editor:—A short time ago, while operating on a patient who had come halfway around the world for his operation, my assistant remarked that my editorial "Surgical Anesthesia" (*Surgery* **35**:643 [April] 1954) had been discussed on staff rounds but that he had not had an opportunity to read it. He asked me to give him the gist of the editorial. I said that the gist of it was that patients should not be allowed to struggle under anesthesia, because I had seen patients struggling under anesthesia break heavy sutures before the wound was closed, and if they struggled after the wound was closed no one could tell whether sutures were broken or not; and, furthermore, that it was my belief that many postoperative hernias developed because of patients struggling under anesthesia and also that many hernia operations were unsuccessful and recurrences developed immediately after operation owing to the same factor. I further mentioned the practice of many anesthetists of sucking out the trachea with a catheter at the end of the operation when the patient is very lightly anesthetized, a procedure that often throws the patient into violent, struggling convulsions, possibly disastrous to the suture line.

As the dressings were being put on this very patient, the anesthetist, with the patient lightly anesthetized, did the selfsame

thing we had been condemning, namely, sucked out the trachea with a catheter. The patient immediately went into violent, convulsive spasms. In order partially, at least, to counteract the effect of this, my assistant and I held our hands over the operative site, exerting all the pressure we could. I told the anesthetist to introduce a little more thiopental (Pentothal) sodium to stop the struggling, which she did with effective results. But, of course, I have no way of knowing whether sutures were broken and probably will not know for several months whether the patient's journey halfway around the world for the operation for his thrice recurrent hernia was futile. I asked the anesthetist if she had not heard the conversation between my assistant and myself about the evils of sucking out the trachea when the patient was lightly anesthetized. She said she had. And yet she went right ahead and did just that! How can such an attitude be explained? I do not believe that she meant to be guilty of not playing on the ball team, but that is exactly what she was guilty of. The proper explanation probably is that she had become so imbued with the importance of certain little routine procedures of the anesthetist that she forgot all about the main object of the entire procedure, which was to cure the man of his thrice recurrent hernia. Instead of keeping her eye on the ball, she had gone off chasing butterflies.

I believe that the practice of sucking out the trachea is very much overdone. In the case just mentioned, the patient had had atropine preoperatively; his anesthetic consisted of only thiopental sodium and nitrous oxide; and there was no evidence that he had any undue amount of moisture in his trachea. Besides, the mucus that causes atelectasis and other respiratory difficulties is much lower down, far beyond the point where it can be reached by suction. If it is necessary to suck out the trachea, certainly the anesthetist should do it before the anesthesia becomes so light that the procedure will cause violent reflex struggling. If, at the end of the operation, after the anesthesia has become light, it is considered necessary to do it, a little additional thiopental sodium will usually abolish the patient's reflexes and avoid trouble. I am informed that in some hospitals it is the practice for the surgeon and his assistant to place their four hands on the abdominal wound and exert pressure at the end of the operation while the anesthetist sucks out the trachea. Such a procedure seems to be entirely illogical and amounts to the surgeon's aiding and abetting improper procedures on the part of the anesthetist. Furthermore, while pressure on the wound during struggling is undoubtedly of some value, I do not believe that it can be counted on to prevent the breaking of sutures, because struggling under anesthesia is often so violent that a little external pressure would have little or no influence on the violent muscular contractions.

After the operation is over, it is highly important for the patient to be given a narcotic as soon as he shows any evidence that he is about to start struggling. This will allow him to sleep the effect of the anesthetic off and not struggle it off. By the time he comes from under the influence of the narcotic, pain will keep him from doing any harm to his wound by struggling. It is also highly desirable, before operation, to discuss with patients their previous narcotic experiences. Often patients know that certain narcotics make them sick and that others do not. Patients also often know that morphine excites them; naturally, in such cases other narcotics should be given. If the patient is given an adequate dose of a suitable narcotic soon after the operation, subsequent narcosis can be held to a minimum.

Surgery is an intricate procedure requiring highly coordinated teamwork on the part of the surgeon, the anesthetist, the house staff, nurses, and orderlies. A break in teamwork on the part of any member of the team may be disastrous to the patient. Certainly the closest teamwork is required between the surgeon and the anesthetist. Both are interested in the general welfare of the patient. Both are specialists in fields of medicine that are very closely related. The type of anesthetic best suited to the patient should be discussed between them before operation. The progress of the operation and the condition of the patient should be subjects of frequent discussion between the two during the operation. Toward the close of the operation the condition of the patient and the depth of the anesthesia should be freely discussed. Certainly the anesthetist should do nothing to the patient to start violent struggling without discussing the matter with the surgeon first. The surgeon should know something of the depth of the anesthesia when the operation is concluded so he can estimate how soon narcotics will be needed in order to prevent struggling. In general, it should never be lost sight of that surgical anesthesia is an adjunct to surgery and not an end in itself. The only reason for the anesthetic is to furnish an aid in the performance of definitive surgery. If anesthesia proves a detriment to the surgical cure, rather than an aid, it is indeed faulty anesthesia.

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UNAUTHORIZED MAGAZINE SOLICITATIONS

To the Editor:—The activities of a magazine solicitor calling himself Fred Carter of Medical Service, Inc., 1000 Park Ave., New York 18, have been brought to our attention, and we felt that we should pass the information along to you in the interest of the medical profession. The Magazine Publishers Association, Inc., is a trade organization comprising the leading magazine publishers of the country, and we maintain in this office a special department for the investigation of complaints in order to protect subscribers from loss in their dealings with magazine subscription solicitors. The accompanying illustration is a copy of a receipt issued by a magazine salesman using the name Fred Carter. This receipt has been prepared to further the fraudulent practices of this solicitor and must be considered a fake printed receipt. The money he has collected has not been turned in, nor have the subscriptions been reported to the publishers. The National Better Business Bureau conducted an investigation and found

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We have sent you this information in the hope that, by putting you on notice regarding this fraudulent solicitor, his activities will not become too widespread and some members of the medical profession will not thereby be defrauded. In the event that you receive any other information on this matter, we should appreciate it if you would forward it to us.

W. O. MORROW
Manager of Complaint Department
Magazine Publishers Association, Inc.
232 Madison Ave., New York 16.

MEDICAL FILM REVIEWS

Cancer Quest: 16 mm., color, sound, showing time 27 minutes. Produced in 1954 for the Wisconsin Division of the American Cancer Society by and procurable on rental ($5) or purchase ($156) from the University of Wisconsin Extension Division, Bureau of Audio Visual Instruction, Madison.

The purpose of this film is to show the nature of the problems of cancer research and some of the specific kinds of research carried on at McArdle Memorial Laboratory at the University of Wisconsin. A man goes to the hospital to visit his wife who just had a benign tumor removed and asks the physician questions rising from his concern for his wife. Answering the questions, the physician starts talking about cancer research and how it studies life on the cellular and molecular level. Past progress in research has made possible recovery from cancer when it is diagnosed and treated early. Sometimes cancer will become inoperable before it is discovered. This problem sets the challenge for cancer research. One research project starts with the study of growth in normal tissue in order to determine if there is a similarity between growth stimulated by estrogens and growth in cancer tissue. The change from normal tissue to cancer is studied through the effect of azo dye on the liver of rats. Azo seems to destroy some growth-limiting factor within the liver cell. The effect of substandard nutrition reducing the incidence of cancer when it is otherwise probable sets the pattern for a variety of experiments to determine if this result can be obtained without the accompanying malnutrition. All the steps in the conversion of food into energy and cell structure are studied in both normal and cancer tissue. Once these steps are known, the chemist can synthesize a chemical that will block the metabolism of cancer but not normal tissue. Many such compounds have been tried, but so far they either destroy normal tissue or they do not stop the cancer growth.

This film shows the conduct of cancer research in a highly organized, extremely technical research laboratory. It consists almost entirely of views of technologists operating various kinds of apparatus and explaining in rather advanced technical terminology what is taking place. The feeble attempts at popularizing the terminology are not too successful. This film is too elementary for a research scientist who knows the equipment and processes involved and it is too advanced for the public. It would probably be of interest and value only to those who are beginning studies and for research technicians in biochemistry, advanced biology, and similar subjects at the college level.

The Use of Gentran as a Plasma Volume Expander: 16 mm., color, sound, showing time 15 minutes. Produced in 1953 by Mervin LaRue, Inc., Chicago, for and procurable on loan from Professional Service Department, Baxter Laboratories, Morton Grove, Ill.

This film illustrates the use and properties of a commercial preparation of the plasma expander dextran. The first part demonstrates by means of experimentation on animals the effectiveness of the expander to restore blood volume in dogs after hemorrhage. One may take exception to the fact that in these experiments the expander is administered immediately after the blood pressure has dropped and that the subsequent rise of pressure is offered as evidence for effectiveness of the treatment. More stringent techniques such as "double bleeding" and comparison with isotonic sodium chloride solution have been developed during the last decade and used as a more convincing proof for the ability of intravenous solutions to restore blood volume. The second part illustrates the use of the compound in clinical medicine, with special reference to favorable results obtained in battle casualties during the Korean war. The final portion demonstrates some features of the commercial manufacture, with emphasis on the advantages of the product and stringent control measures provided to eliminate untoward side-effects. It might have been in order to mention some of the possible disadvantages of dextran that became known during the last years, such as moderate storage in reticuloendothelial cells, disturbance of hemostasis expressed in prolongation of bleeding time, and especially the possibility of allergic reactions in patients sensitized to certain bacterial antigens serologically related to dextran. It also does not appear that testing for antigenicity in rabbits is a reliable method of assuring absence of antigenicity in man. On the positive side, general hazards of intravenous therapy are well described, and emphasis is placed on the fact that plasma expanders cannot compensate for loss of blood as far as its oxygen-carrying capacity is concerned. The photography and story are well done. If accompanied by comments of a critical observer, the film will be useful in acquainting medical students, residents in surgery, and general practitioners with the potential usefulness of dextran as plasma expander.

Working for Better Public Health Through Recognition of Feeling: 16 mm., black and white, sound, showing time 25 minutes. Produced in 1954 by and procurable on loan from Communicable Disease Center, P. O. Box 185, Chamblee, Ga.

This film uses the psychological approach to solving problems in human relations. With the local health department used as the setting for many of the irritations that can exist between health department staff and the citizens with whom they work, there are illustrated many of the kinds of misunderstandings that are based on the staff person's unwillingness or inability to appreciate the feelings of the other person. The main narrative concerns the relations between a sanitarian and the operator of a dairy farm who almost come to blows over the condition of milk cans. After developing an insight into how the dairy farmer might be approached, the sanitarian finally has a successful conference and accomplishes his objective. Since this film brings into focus not only the environmental sanitation problems but the problems of the public health nurse and those of the clerk in the clinic, it sets the pace for the development of improved human relations in the entire health department program. This film would be useful in the postgraduate training of staff members of health departments and others who have dealings with the public in an authoritative manner required under the law. It would be useful also in the undergraduate and graduate training of professional persons in schools of public health and schools of social work.

Syphilitic Venereal Disease: 16 mm., color, sound, showing time 25 minutes. Prepared by Evan W. Thomas, M.D. Produced in 1954 by Sturgis Grant Productions, New York, for and procurable on loan from E. R. Squibb & Sons, 745 Fifth Ave., New York 22.

The purpose of this film is to organize and clarify for the physician the stages and types of syphilis, explaining the course of the disease in terms of the pathological processes initiated by the infecting organism, Treponema pallidum, and illustrating the variety of signs and symptoms by clinical material, to the end that correct diagnosis may be made and proper treatment given. The stages of syphilis are clearly defined, and the mode of invasion by the treponemas and generalization of the infection are described and schematically illustrated. Several genital and extragenital chancres and the cutaneous secondary eruption are demonstrated; the technique of procuring specimens for darkfield examination and an excellent darkfield demonstration of the treponemas is presented. Serologic tests for syphilis are shown and briefly discussed. The viewer is oriented in regard to late symptomatic syphilis, particularly cardiovascular and neurosyphilis, by concise definition and helpful diagrams. The tambour aortic second sound and the murmurs of aortic regurgitation are presented effectively on the sound track. What constitutes adequate treatment of the various stages of syphilis is still a controversial subject, and the total dosages as cited by the narrator may be considered as conservative by many syphilologists. The narrator, however, emphasizes by repetition that higher total penicillin dosages may be indicated and justifiable.

The value of this film would be greatly enhanced if better photographic examples of genital and extragenital chancres were substituted and if pictures of mucous patches and condylomata lata were included. The technique of the intramuscular injection shown is also questionable for teaching purposes. The film is well organized, effectively narrated, and on the whole is a satisfactory presentation of the clinical and laboratory diagnosis and treatment of acquired syphilis. It is suitable for audiences of physicians, junior and senior medical students, nurses, social service workers, and public health personnel.

MEDICAL LITERATURE ABSTRACTS

INTERNAL MEDICINE

Calcification of the Mitral Valve Annulus and Its Relation to Functional Valvular Disturbance. M. A. Simon and S. F. Liu. Am. Heart J. **48**:497-505 (Oct.) 1954 [St. Louis].

Calcification of the mitral valve annulus was found at autopsy in 59 (10%) of 590 hearts of persons of all ages. By excluding 119 specimens obtained from persons less than 10 years of age, the incidence of calcification of the mitral valve annulus rose to 12.5% in persons over 50 years of age. Variable degrees of calcification of the aortic valve were associated with calcification of the mitral valve annulus in 16 (27%) of the 59 hearts, while a pathological diagnosis of rheumatic heart disease was made in only 3 cases. In 15 (62.5%) of 24 selected cases of mitral annulus calcification in which clinical data were available apical systolic murmur presumably referable to the mitral valve had been heard. In 9 (60%) of these 15 cases the quality of the murmurs was such (loud, rough, or musical) as may be associated with functional derangement at the mitral orifice, and in 5 cases (33.3%) a clinical diagnosis of mitral regurgitation had been made. In the light of the newer knowledge of the mechanics of the closure of the mitral valve, it is suggested that extensive calcification of the annulus of the mitral valve interferes with the rhythmic muscular contraction of the mitral ring by forming a rigid, noncompressible segment of that ring. Thus, the gap to be bridged may not be sufficiently reduced to permit overlapping closure by the mitral leaflets. This concept of interference with contraction of the valve ring, together with the observation that 60% of apical systolic murmurs in the authors' proved cases of mitral annulus calcification suggested mitral dysfunction, may be considered as presumptive evidence that extensive calcification of the mitral annulus (without rheumatic involvement of the leaflets) may produce relative or frank mitral regurgitation.

Mitral Valvulitis Associated with Interauricular Communication. Y. Bouvrain and A. Sibille. Semaine hôp. Paris **30**:3414-3424 (Oct. 6) 1954 (In French) [Paris, France].

Ninety-six cases of combined interauricular septal defect and mitral lesion are reviewed, beginning with a patient of Corvisart's in 1811 and ending with five cases reported by the present authors and their colleague Soulié in 1954. The anatomic features of this syndrome may vary widely. The state of the mitral valve may range from atresia to insufficiency. The lesions may have the appearance of either the endocarditic or the congenital type. The pulmonary artery is usually greatly augmented in volume, but there are exceptions to this. The aorta is generally small, sometimes even aplastic, the blood flow being insured by the pulmonary artery through a patent ductus arteriosus. The right auricle is almost always greatly dilated and hypertrophied, while the left auricle is not so enlarged; it may be normal. The left ventricle is always dilated and hypertrophied and the right one smaller than the left, though it may be either greater or smaller than normal. The other valves of the heart and great vessels are often affected. Diagnosis of the condition is difficult, because the syndrome does not have a characteristic aspect but may be dominated by various symptoms of one defect or the other, as well as of associated lesions. The presence of the septal defect modifies the course of the mitral disease; by reducing the pressure within the heart and allowing a left-to-right shunt, it makes the mitral disease more tolerable. Death is usually due to cardiac insufficiency, with cyanosis, edema, and hepatomegaly. Some patients enjoy remarkable longevity, but the average age of death is 35. Cardiac catheterization will demonstrate the presence of the communicating defect, but associated mitral disease may not be obvious and should be looked for.

Prevention of Systemic Arterial Embolism in Chronic Rheumatic Heart Disease by Means of Protracted Anticoagulant Therapy. J. C. Wood and H. L. Conn Jr. Circulation **10**:517-523 (Oct.) 1954 [New York].

Seven outpatients with mitral stenosis and chronic auricular fibrillation complicated by previous systemic arterial embolism have been given anticoagulant therapy for periods of 20 to 48 months (a total of 214 months). Before therapy, 10 embolic episodes had occurred in this group, whereas during therapy there has been only one. A patient had an episode of mental confusion and apparent slight right-sided weakness that cleared without residuum within 24 hours; this occurred when the prothrombin value was 32%. Two patients had systemic embolism during periods of temporary withdrawal of bishydroxycoumarin (Dicumarol) therapy. Another experienced pulmonary infarction when heparin administration was interrupted. Hemorrhagic phenomena of a degree sufficient to necessitate vitamin K_1 therapy occurred on three occasions. The therapeutic risk attendant to anticoagulant therapy seems justified, in view of the frequency of embolism in mitral stenosis with auricular fibrillation and the number of deaths from thromboembolism. Absolute protection from embolism is not guaranteed by anticoagulant therapy, since it is practically impossible to maintain a therapeutically effective prothrombin time in all patients at all times. The selection of patients for prolonged anticoagulant therapy must be made with the fact in mind that the program is not simple and requires close individual attention to insure safety. Bishydroxycoumarin should not be administered to ambulatory patients in the absence of adequate laboratory and clinical control. Because of the danger of local hemorrhage, it is probably good policy to avoid using anticoagulants immediately after a cerebral embolism. Serious hemorrhage is not expected to occur, but the patient should be prepared for occasional hemorrhagic manifestations. These can usually be easily controlled with administration of vitamin K_1, which is superior to water soluble analogs. Once instituted, unless the basic situation is changed by mitral commissurotomy or some other factor, there is no way of selecting a safe point for withdrawal. Therapy probably should be continued indefinitely in most patients. Although not substantiated, the possibility exists that a temporary state of relative hypercoagulability follows withdrawal of anticoagulants.

Carcinoma of the Lung: A Report of 403 Cases. D. P. Boyd, M. I. Smedal, H. B. Kirtland and others. J. Thoracic Surg. **28**:392-411 (Oct.) 1954 [St. Louis].

The symptoms that patients with cancer of the lung have are unfortunately nonspecific, and cough and chest pain, which are the commonest of all, are found in a number of intrathoracic diseases, many of which are benign. Bronchogenic carcinoma, therefore, may be mistaken for intrathoracic and constitutional disease of almost every kind, especially unresolved pneumonia, virus pneumonia, tuberculosis, influenza, asthma, angina pectoris, and diaphragmatic hernia. The low survival rate in patients with lung cancer is partly due to the fact that the disease is usually advanced by the time the patient is referred to a thoracic specialist; thus, over 25% of 403 such patients seen at the Lahey

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The place of publication of the periodicals appears in brackets preceding each abstract.

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Clinic during the last 15 years had had their principal symptoms for more than a year. Some improvement in the direction of earlier diagnosis was found when the patients were divided into two groups (159 seen before Jan. 1, 1948, and 224 seen between Jan. 1, 1948, and December, 1952) to permit assessment of the results of treatment in terms of five year survivals. Almost 75% of 204 in the second group were referred after six months or less of treatment by their local physicians, whereas only about 60% of 117 in the first group were so referred. The importance of (1) frequent and repeated roentgenologic surveys of the chest, (2) the follow-up of every abnormal shadow found, and (3) the follow-up of every thoracic symptom until it is explained cannot be too strongly emphasized if the percentage of patients seen during the operable stage of their disease is to be increased. The diagnosis was established by roentgenography, the most consistently accurate diagnostic method available, in 364, or about 90%, of the 403 cases. Many of these, however, were far advanced, and new techniques in roentgen diagnosis, such as the use of high-voltage radiography, are urgently needed to make earlier detection of intrabronchial lesions possible. The average duration of survival of all patients was 10.7 months after discharge from the hospital or clinic. Patients treated medically had an average life duration of only 4.2 months; those given x-ray therapy had an average life duration after leaving the hospital of only 7.9 months; and those subjected to pulmonary resection lived an average of 27.9 months. The marked superiority of surgical as compared to medical or x-ray treatment of lung cancer is further shown by the fact that, whereas the five year survival rate for all patients was 9.5%, for those in whom a curative resection was performed it was 37.8%. Eleven of the 15 patients who survived five years or more are still living and apparently free from disease; one died of recurrence at five years and one month; and two others are believed to have recurrences. The remaining five year survivor, who was subjected to thoracotomy and had a positive biopsy at the clinic, was given x-ray therapy only and is now reported to be in failing health from metastasis. The maximum survival period so far is 12 years.

Pulmonary Tuberculosis Relapse and Mortality. M. G. Stephens. Am. Rev. Tuberc. **70**:601-609 (Oct.) 1954 [New York].

Stephens reports on 1,213 employees of the Metropolitan Life Insurance Company who were first treated for pulmonary tuberculosis at the company's sanatorium at Mt. McGregor, N. Y., between 1919 and 1944 and were followed to 1949; 648 were men whose median age was between 30 and 34 years, and 565 were women whose median age was between 20 and 24 years. This difference in age distribution was due largely to the difference in age distribution of the total employee group. Of the 648 men, 176 (27.1%) had minimal disease, 321 (49.6%) had moderately advanced disease, and 151 (23.3%) had far-advanced disease. Of the 565 women, 254 (45%) had minimal disease, 239 (42.3%) had moderately advanced disease, and 72 (12.7%) had far-advanced tuberculosis. In 218 of the 1,213 patients treatment was terminated by death. The percentage of deaths increased with the increase in the stage of tuberculosis on admission for both the men and women; 2 (1.1%) of the men and 8 (3.1%) of the women with minimal tuberculosis died, 52 (16.2%) of the men and 48 (20.1%) of the women with moderately advanced disease died, and 67 (44.4%) of the men and 41 (56.9%) of the women with far-advanced disease died. The pronounced difference in the percentage of deaths among those with minimal and advanced disease indicates the value of detecting tuberculosis and starting hospital treatment in an early stage. Of the 1,213 patients, 968 were followed up for a 5 year period and 787 for a 10 year period. Relapse of tuberculosis after completion of the treatment was lowest for those who had minimal tuberculosis. The rate of relapse at each stage of disease decreased with the number of years elapsed after completion of treatment. In each stage the women had a more favorable experience than the men. Age at the beginning of treatment did not seem to have a definite influence on the occurrence of relapses except for those occurring in women in the minimal stage of the disease: those women who began their hospital treatment when they were less than 25 years of age had a higher relapse rate of their disease than those who began treatment at 25 years or older. Patients who were treated for longer periods of time tended to have lower rates of relapse. The mortality after completion of first treatment was calculated by sex and stage of disease and was compared with the mortality rates of Metropolitan Life Insurance Company employees insured under the Group Annuity Contract. The mortality of the tuberculous patients after completion of first treatment increased with the increase in stage of disease. The mortality was higher among the women than the men.

Some Serious Complications of Tuberculous Lymph Nodes: Fatal Hemoptysis, False Aneurysm, Occluded Cisterna Chyli, and Obstructive Jaundice: A Review with a Report of Five Cases. G. L. Gale. Am. Rev. Tuberc. **70**:610-622 (Oct.) 1954 [New York].

The occurrence of serious complications of tuberculous lymph nodes is reported in two men and two women between the ages of 23 and 69 years and in a 15-year-old boy treated at the Toronto Hospital for Tuberculosis, Weston, Ontario, Canada. The complications that caused the death of four of the five patients were: (1) fatal hemoptysis from erosion of a bronchial artery caused by a tuberculous lymph node that had ulcerated into the left main bronchus; (2) fatal hematemesis from erosion of a varicose esophageal vein, caused by a tuberculous esophagocutaneous fistula, the source of which was a caseating tracheobronchial lymph node; (3) fatal hemorrhage from a false aneurysm, resulting from a sloughing para-aortic lymph node that had eroded into the abdominal aorta on the one side and into the third part of the duodenum on the other; (4) fatal occlusion of the cisterna chyli by tuberculous granulation tissue from the inguinal, external iliac, common iliac, and para-aortic lymph nodes. The fifth patient, who survived, had obstructive jaundice from pressure on the common bile duct by tuberculous lymph nodes in the region of the first part of the duodenum. The patient was given a course of therapy with 0.5 gm. of streptomycin twice daily and 14 gm. of *p*-aminosalicylic acid daily for 100 days; it only made the infection quiescent but did not achieve healing. A flare-up took place one month after the end of this chemotherapeutic course. Laparotomy established the diagnosis, and a second course of treatment with streptomycin and *p*-aminosalicylic acid completed the cure. The modern treatment of tuberculous lymph nodes by long-term antimicrobic drugs should result in fewer serious complications.

Acute Hepatic Insufficiency of the Chronic Alcoholic: Clinical and Pathological Study. G. B. Phillips and C. S. Davidson. A. M. A. Arch. Int. Med. **94**:585-603 (Oct.) 1954 [Chicago].

The clinical manifestations and the hepatic histology of 56 chronic alcoholic patients with liver disease were examined. Characteristic histological abnormalities, consisting of severe degrees of hyaline degeneration, liver cell necrosis, and parenchymal disorganization, were observed in 18 patients who died with acute hepatic insufficiency. Fibrosis was a constant feature of this pathological picture. Hepatic fat was usually present, but the characteristic lesion appeared to be independent of the amount of fat. Eleven of these 18 patients were women. All but one were jaundiced, often with acholic stools. Most of them had progressive polymorphonuclear leukocytosis, and all died in hepatic coma, usually spontaneous. Of the remaining 38 patients, most of whom lived, 10 showed the same lesion complex in moderate to marked degree in liver biopsy specimens. Lesser degrees of the lesion complex were usually associated with lesser degrees of acute hepatic functional impairment. Hepatic fat and fibrosis were seen frequently without the characteristic lesion complex and were usually associated with less clinical evidence of active liver disease and a better immediate prognosis. It is concluded that chronic alcoholics may have a typical hepatic lesion complex characterized by the three elements mentioned. It is distinct from the fatty lesion and is usually responsible for the clinical evidence of acute severe liver impairment, which may slowly improve but often leads to fatal hepatic coma.

SURGERY

Valvular Heart Disease: The Role of Cardiac Catheterization in Preoperative Evaluation. A. Selzer and H. W. Bradley. California Med. **81**:251-255 (Oct.) 1954 [San Francisco].

Cardiac catheterization performed in research laboratories showed that, of the various types of valvular heart disease, advanced mitral stenosis is associated with a characteristic dynamic pattern that is reversible by mitral valvulotomy. In the selection of patients for mitral valvulotomy, occasionally there are cases in which a decision cannot be reached on the basis of ordinary clinical methods of examination. Four illustrative cases in a 30-year-old woman and in three men between the ages of 37 and 43 are described, one of which shows the average hemodynamic findings in a typical case of mitral stenosis and the change that takes place after successful valvulotomy, while the three others exemplify the main problems in presurgical evaluation in which help can be expected from cardiac catheterization. Such aid is greatest in two categories of cases. The first category is mild mitral stenosis, in which normal or almost normal cardiac dynamics make it most unlikely that the patient suffers from the result of mitral valve obstruction and therefore unlikely that operation on the valve would be of benefit. Conversely, the dynamic pattern of significant mitral stenosis exists occasionally in cases in which cardiac strain and enlargement are not yet recognizable by electrocardiographic and roentgenographic changes but in which mitral stenosis may cause incapacitating symptoms that might be relieved by surgical intervention even though clinical findings in regard to the heart are within normal limits and lead to erroneous conclusions that symptoms are extracardiac. The second category is that of combined valvular lesions, in which it is important to determine whether mitral stenosis is the predominant lesion and is primarily responsible for the incapacitating symptoms, for in such cases mitral valvulotomy can be of benefit. The most important feature of the dynamic pattern of mitral stenosis in such cases is the low and static cardiac output, which, in the absence of severe aortic stenosis, strongly suggests tight mitral stenosis, for usually in mitral or aortic insufficiency there is some increase of blood flow on exercise. Elevated pulmonary arterial pressure may be present in mitral insufficiency and in aortic valve defects combined with left ventricular failure. However, severe pulmonary hypertension is strongly indicative that mitral stenosis is predominant. Finally, pulmonary wedge pressure, i. e., pressure tracing recorded with the catheter wedged firmly into a smaller branch of the pulmonary artery, may reveal the presence of mitral insufficiency. While routine use of cardiac catheterization as an aid to preoperative diagnosis in valvular heart disease is neither indicated nor desirable, it permits the preoperative assessment of some cases in which diagnosis is in doubt, by providing information otherwise unobtainable.

Treatment of Certain Coarctations with Homologous Grafts, Fixed in 4% Formalin. J. F. Nuboer. Arch. chir. neerl. **6**:123-142 (No. 2) 1954 (In English) [Arnhem, Netherlands].

In the surgical treatment of stenosis of the aortic isthmus after removal of a portion of the aorta, a direct suture is possible only when the aortic arch and the subclavian artery and the descending aorta have to a certain extent been mobilized; even then the suture is still more or less in a condition of tension. This technique, described by Crafoord, is feasible in the majority of patients, but the cases in which a direct suture is impossible or dangerous are comparatively numerous. Nuboer mentions the methods suggested by Blalock and Clagett for these cases but also shows that these methods have certain disadvantages. He further shows that Gross succeeded in bridging the defect by using the method of homologous transplantation of aortas obtained from young persons within four to six hours after death, under aseptic precautions. The graft is preserved in a modified Tyrode solution at 3 to 4 C and is available for use for five or six weeks. Before Gross's experiences with this method had been published, investigations had been started at the surgical department of Utrecht University Hospital into the possibility of employing homologous grafts fixed in a 40% solution of formaldehyde (Formalin) for arterial grafting. Previously it was reported by Nuboer's colleagues that, provided fixing and preserving are done well, homologous arterial grafts fixed in solution of formaldehyde are in no respect inferior to fresh homologous grafts. There are even advantages, since the elastica breaks up much later than is the case in fresh homologous grafts. A homologous graft fixed in solution of formaldehyde was used in 8 of 19 patients treated at the author's clinic for coarctation at the aortic isthmus. The histories of these eight patients are presented in this paper. In one of these cases the graft did not remain patent, probably because during operation the aorta at a distance from the stenosis was thrombosed. The patients' ages ranged from 17 to 45. One patient died 14 months after the operation following multiple rheumatic valve defects; the graft proved to be perfectly incorporated in the system and amply wide. Although the postoperative period is too short for a final judgment on the value of aortic grafts fixed in solution of formaldehyde, the results so far indicate that they have no drawbacks in comparison to fresh homologous grafts.

Ruptured Aneurysms of Abdominal Aorta: Excision and Homograft Replacement. D. A. Cooley and M. E. DeBakey. Postgrad. Med. **16**:334-342 (Oct.) 1954 [Minneapolis].

Of 48 patients with aneurysm of the abdominal aorta who underwent aortic resection with homografting at the department of surgery of Baylor University College of Medicine in Houston, Texas, during the past few years, perforation had occurred at the time of the surgical intervention in 5, in whom the procedure was done as an emergency for this reason. Of these five patients, four were men between the ages of 50 and 67 and one was a 78-year-old woman. Two 67-year-old men and the woman died within 5 to 12 days after the surgical intervention; all three had evidence of generalized arteriosclerosis before the acute illness, and operation was unavoidably delayed for from 10 hours to nine days after the onset of symptoms. All three patients seemed to tolerate the operation satisfactorily but died subsequently of complications of the underlying vascular disease (renal and cardiac failure, uremia, and coronary occlusion). The two survivors were men, aged 55 and 50 years, respectively, both of whom had been physically active until the time of rupture of the aneurysm. This may, in large measure, have determined survival in these two patients as opposed to the others in this group; their ages were considerably below the 62.3 year average age in the nonperforated cases. It appears that if operation under such circumstances is to be successful, early diagnosis and aggressive management of these patients are mandatory. Resection with replacement by aortic homograft for uncomplicated aneurysms of the aorta has proved to be an effective method of therapy. The successful application of this procedure in two of the authors' five cases of ruptured aneurysm suggests that it is the most effective treatment for this lethal complication. Since this paper was submitted, another patient, a 46-year-old man whose acute symptoms began 24 hours before the surgical intervention and who traveled 120 miles by ambulance to the hospital, was successfully operated on for ruptured aneurysm of the abdominal aorta; the aortic reconstruction was done with a bifurcation homograft.

Effect of Adrenalectomy and Oophorectomy in Treatment of Far Advanced Carcinoma of Breast. W. F. Roe and C. J. Berne. West. J. Surg. **62**:457-461 (Sept.) 1954 [Portland, Ore.].

Roe and Berne present observations on five patients who were subjected to oophorectomy and adrenalectomy about one year ago. All had far-advanced breast cancer, which had been previously treated by radical mastectomy followed by roentgen therapy to the breast region and to metastases. Estrogen or testosterone therapy had been tried in some of them. The cancer was progressive in all of the patients. Cortisone was given in doses of 200 mg. before and 100 mg. after oophorectomy and adrenalectomy on the left side, then 400 mg. before and 300 mg. the first 24 hours following adrenalectomy on the right side. The amount was then gradually diminished until the total daily dose ranged from 25 to 50 mg. Two of the five patients were not benefited; these two patients had duct carcinoma. The three who had remission of one year's duration had alveolar or papillary carcinoma. Estrogen withdrawal probably explains the action of these operations. Adrenalectomy and oophorectomy can probably be recommended in all patients with far-advanced breast cancer in whom other palliative measures have failed.

BOOK REVIEWS

Biochemistry of Cancer. By Jesse P. Greenstein, Chief, Laboratory of Biochemistry, National Cancer Institute, National Institutes of Health, United States Public Health Service, Bethesda, Maryland. Second edition. Cloth. $12. Pp. 653, with 64 illustrations. Academic Press, Inc., 125 E. 23rd St., New York 10, 1954.

This new edition of a valuable reference work deals accurately and exhaustively with the biological as well as the chemical aspects of neoplastic disease, thereby providing the investigator with a reliable and useful tool. The style is clear and readable, and the format is attractive. The chemical aspects of tumor induction and the chemistry of tumors and of the tumor-bearing host are given special stress. The control of tumor induction and tumor growth is given less thorough treatment than other aspects of the subject, and here the clinical features are cautiously but accurately considered. Because of its importance the resistance of tumors to chemotherapy should have been discussed more fully. The author concludes that the biochemical similarity of tumors to each other justifies further study of the chemotherapy of cancer. This volume should be read by every investigator interested in cancer, and clinicians and pathologists should find it a stimulating work.

Manson's Tropical Diseases: A Manual of the Diseases of Warm Climates. Edited by Sir Philip H. Manson-Bahr, G.M.G., D.S.O., M.D., Consulting Physician to Hospital for Tropical Diseases, London, England. William Wood book. Fourteenth edition. Cloth. $12.50. Pp. 1144, with 440 illustrations. Williams & Wilkins Company, Mount Royal and Guilford Aves., Baltimore 2, 1954.

The 14th edition of this well-known manual matches the excellence of the previous ones. The inclusion of essential new information has made it necessary to abandon former chapters on diet and nutrition and detailed historical discussions that appeared in conjunction with each chapter. The book is subdivided into sections primarily from the viewpoint of the clinician. The beginning chapters present information concerning preparations for residence in the tropics, life in tropical climates, and the illnesses that may be encountered there. The main portion of the book is comprised of sections on fevers, vitamin deficiency diseases, abdominal diseases, infective granulomatous diseases, diseases of the central nervous system, venereal diseases, skin diseases, local diseases, animal parasites and associated diseases, diseases due to poisons, and special subjects. The last-named section covers general information on the technique of injections and blood transfusions, chlorophenothane (DDT) and other insecticides, and a table of drugs used in the treatment of tropical diseases. A general index with main references in boldface type appears at the end. The printing, illustrations, and binding are excellent. The style, spelling, and nomenclature follow British custom. Some preference is given to trade names and abbreviations for drugs, and all generic names for drugs follow the British Pharmacopoeia. Despite this, clinicians and field workers who reside or expect to reside in the tropics should find the book a highly useful guide for reference.

Endemic Goiter: The Adaptation of Man to Iodine Deficiency. By John B. Stanbury, M.D., et al. Harvard University monographs in medicine and public health number 12. Editorial committee: A. Baird Hastings, Chairman, et al. Cloth. $4. Pp. 209, with 53 illustrations. Harvard University Press, Cambridge 38; Oxford University Press, Amen House, Warwick Sq., London, E.C.4, England, 1954.

This monograph is an account of experiments carried out by investigators from Harvard University, Massachusetts General Hospital, the University of Cuyo, and the Central Hospital of Mendoza, Argentina, on endemic goiter as it occurs in Mendoza, one of the western-most provinces of Argentina. When the attention of Prof. James H. Means of the thyroid clinic of the Massachusetts General Hospital was drawn to the existence of a large number of patients with untreated endemic goiter in this province, he instigated the sending of an expedition to this area to study these patients by modern methods and to uncover new facts concerning iodine metabolism and the physiology of the thyroid. After a brief description of the Mendoza area and the large incidence of goiter in the inhabitants, the authors describe the methods used in studying their 129 patients and the present concepts regarding the metabolism of iodine. They studied not only the uptake and excretion of iodine but also the effects of desiccated thyroid, methimazole, and thyrotropin on iodine exchange and hormone production. The results were then analyzed to determine the functional interrelation of the thyroid gland as disclosed by their observations. As was to be anticipated, the uptake of iodine by patients with goiters is higher than that of normal persons. On the other hand persons with cretinism had a normal organic iodine content of the blood. By means of complex mathematical analyses of the results the changes that occur when the goitrous thyroid compensates for iodine deficiency are quantitatively defined. The authors are all well-known investigators in this field, and they have presented a basic study of thyroid and iodine metabolism. The book is too complex and theoretical to appeal to the general practitioner particularly since, as stated by Dr. Means in the foreword, "There is no practical problem—at least not a medical one—concerning endemic goiter." To the research worker and those interested in thyroid physiology, the book should prove indispensable and stimulating.

Directory of Professional Motion Picture Films and Authors. Cloth. Pp. 330. Professional Publications, 2010 Kentucky St., Lawrence, Kan., 1954.

This volume is a comprehensive, classified, reference book on medical and dental motion pictures and their authors. Descriptive information as well as complete data on their availability are given for about 2,400 medical and 380 dental films. Each film is listed under its appropriate specialty. References to reviews in THE JOURNAL and to approval by the American College of Surgeons are included for those films that have been evaluated by these organizations. Notations are made of those films that are available in foreign language versions. A section containing brief biographies of each author is also included. Although this publication does not represent an evaluated list of medical and dental films, it does provide a rather comprehensive list of such films available.

The Vitamins: Chemistry, Physiology, Pathology. Volume II. Edited by W. H. Sebrell, Jr., Director, National Institutes of Health, Bethesda, Maryland, and Robert S. Harris, Professor of Biochemistry of Nutrition, Massachusetts Institute of Technology, Cambridge. Cloth. $16.50. Pp. 766, with illustrations. Academic Press, Inc., 125 E. 23rd St., New York 10, 1954.

The second of a three volume series, this book provides a continuation of a comprehensive review on the chemistry, physiology, and results of deficiency of the following additional members or groups of the vitamins and related dietary factors: choline, vitamin D group, essential fatty acids, inositols, vitamin K group, niacin, and pantothenic acid. Basic scientific and clinical aspects of each of these substances are discussed in a series of articles by 29 contributing authors. Each section includes references to the sources of information cited in the text. The binding and format are excellent and conform to the color and size of the preceding volume in the series. This textbook should be useful as a comprehensive and current reference in this field for those persons who have a specialized interest in vitamins.

These book reviews have been prepared by competent authorities but do not represent the opinions of any official bodies unless specifically so stated.

QUERIES AND MINOR NOTES

NIGHT SWEATS

TO THE EDITOR:—*What is the cause of night sweats in persons past the age of 50 years, without apparent reason, there being no abnormal findings on physical examination? Is any drug of benefit for patients who sweat easily during day or night?*

Irving I. Crouse, M.D., Buffalo.

ANSWER.—Excessive sweating may be due to febrile, thermal, or emotional causes. The attacks may occur at any time of the day or night but, in certain syndromes, are oftener at night. In the cases mentioned by the questioner, one would have to obtain more information regarding the time and circumstances under which the excessive sweating occurs. If suggested by the history or the physical examination, laboratory studies such as sputum examination, chest x-ray, basal metabolic rate determination, electrocardiography, blood cell count, differential blood smear analysis, and urinalysis may be indicated. Pulmonary tuberculosis, early heart failure, bronchiectasis, toxic diffuse goiter (Grave's disease), or malaria may cause this type of sweating. Obesity and the menopausal syndrome have also been implicated. Many persons complain of such sweats although no organic or emotional basis for them is demonstrable. Atropine, scopolamine, and methantheline bromide, as well as most of the newer anticholinergic drugs, are useful in symptomatic treatment; however, the dose required may need to be large enough to produce the usual side-effects of dry mouth, blurred vision, and urinary retention. Small doses of barbiturates or bromides may be helpful for sweating of emotional origin. The treatment of sweating due to overheated rooms, excessive bed clothing, and obesity is obvious.

QUINIDINE FOR MUSCULAR CRAMPS

TO THE EDITOR:—*Following removal of an intervertebral disk at a lumbosacral joint that had produced symptoms referable to the distribution of the first sacral nerve, a patient after a lapse of about six months began to have severe muscular cramps in his calf muscles and the upper posterior portion of his thigh. These cramps occur mostly at night although on occasion they have come on during the day when the leg has been held in certain positions. They are excruciating, often waking the patient from sleep. No fusion was performed, as no back trouble was present and roentgenograms revealed excellent spinal structures. Taking 0.2 gm. of quinidine sulfate at bedtime seems to lessen or prevent the cramps altogether. 1. What might be the cause of such cramps? 2. What is the mode of action of quinidine in such a patient, and how long may a person take such medication without any untoward effects?*

M.D., New York.

ANSWER.—Nocturnal cramps in the calf and posterior thigh muscles are not a characteristic symptom of herniation of a lumbar intervertebral disk. Muscular cramps of the type described in this inquiry are more characteristic of vascular insufficiency from either arteriosclerosis or vasospasm, or both. Quinine, which is the basic alkaloid in quinidine sulfate, has a curare-like action on voluntary muscle. Whether the stated dose of 0.2 gm. of quinidine sulfate would produce a significant effect on the voluntary muscles of the affected leg is questionable. This is a minimal therapeutic dose and may be taken indefinitely without any harm. In this case it would seem that the most important study to be made is the vascular competency of the affected leg. The patient should have a further neurological check-up to make sure that the former herniation of the intervertebral disk has not recurred.

The answers here published have been prepared by competent authorities. They do not, however, represent the opinions of any official bodies unless specifically so stated in the reply. Anonymous communications and queries on postal cards cannot be answered. Every letter must contain the writer's name and address, but these will be omitted on request.

ELASTIC HOSE WORN AFTER THROMBOPHLEBITIS

TO THE EDITOR:—*What is the current opinion on the continued wearing of elastic stockings after subsidence of acute thrombophlebitis of one leg? Is it advisable to wear stockings on both legs after it has occurred in only one leg, regardless of supposed cause? Have there been any reports of patients who have worn them for more than three years? Have studies been done on the structure of the vein walls of a patient who has worn a stocking for this period of time?*

Ford C. Spangler, M.D., Salem, N. J.

ANSWER.—Elastic hose is worn after subsidence of acute thrombophlebitis simply for reducing swelling and counteracting the increased venous pressure in the superficial venous system. There is also some evidence that, at least in the horizontal position, this aid accelerates deep venous circulation. The elastic hose is just a type of crutch that should preferably be discarded if surgical measures are possible and not contraindicated. The hose has to fit very accurately, preferably made to order, and need only be worn on the involved extremity. Patients who have worn such hose for a number of years may gradually discontinue the use of the hose if better collateral circulation has developed under the fascia; one can only judge this by the amount of discomfort and swelling that discontinuation of the hose produces. No studies are available on the structure of the walls of the vein in a patient who has worn a stocking for three years or more. It is, however, well known that collateral veins developing as a result of deep venous obstruction will have much scarring, loss of muscular wall, and repeated bouts of low grade infection.

REGIONAL ILEITIS

TO THE EDITOR:—*A 36-year-old woman has regional ileitis of the terminal ileum. This condition was proved in operation one month ago, at which time a side-tracking ileotransverse colostomy and biopsy of the involved area were done. There was no segmental involvement elsewhere and no abscess or fistulous formation in the involved area of 8 in. (20.3 cm.) of the terminal ileum. Has corticotropin (ACTH) and/or cortisone been used in these cases, and, if so, with what results?*

Frank H. Robinson, M.D., Chula Vista, Calif.

ANSWER.—A summary of the treatment of regional enteritis by Van Patter and others appeared in *Gastroenterology* **26**:347-450 (March) 1954. Both cortisone and corticotropin have been used extensively in the treatment of this condition with indifferent results. Immediate improvement is sometimes striking. Serious complications may be associated with the treatment. Relapses commonly occur when the treatment is stopped.

AMYOTROPHIC LATERAL SCLEROSIS

TO THE EDITOR:—*I would appreciate information concerning the treatment of amyotrophic lateral sclerosis. Are any of the vitamins or amino acid mixtures of value?*

Herbert R. Ellis, M.D., Tracy, Calif.

ANSWER.—Treatment of amyotrophic lateral sclerosis is unsatisfactory, and no form of therapy is generally recognized. The use of vitamin E, proposed some years ago, has proved extremely disappointing, and the results of the use of various amino acids and vital dyes are equivocal. Progress of the disease is clearly delayed if the general level of nutrition is maintained, and tube feeding is valuable even in the early stages of dysphagia. Aside from the classical form described by Charcot, with fibrillation and atrophy in the upper extremities, tongue, and pharynx, there are many milder forms, for example, beginning in the legs or involving only one extremity. These are often milder, and the symptoms may become stationary or regress. This fact must be borne in mind in assessing treatment.

BUS DRIVERS AND CORONARY OCCLUSIONS

To the Editor:—*I cannot concur with your consultant's reply to the query entitled "Bus Drivers and Coronary Occlusion" on page 802 of* The Journal *for Oct. 23, 1954. For eight years I was an autopsy surgeon to the coroner of Los Angeles County, California. I am familiar with two aircraft crashes in which eye-witness accounts of the crashes plus the autopsy findings indicated sudden death of the pilot from coronary disease. About three years ago the pilot of a trans-Pacific plane suddenly died of a coronary attack some hours out of San Francisco. These men had meticulous physical examinations not long before death. I have performed many autopsies on persons who died suddenly of coronary disease without any history suggestive of prior symptoms. I have performed a number of autopsies on persons who died at the wheels of automobiles and killed others. Any pathologist with wide experience in such work has knowledge of similar cases.*

The bus driver is harassed not only by passengers but by adverse weather and road conditions and by careless drivers with whom he has to compete for right-of-way. The driver in question is admittedly "slightly hypertensive," whatever that may be, and has had "a severe coronary occlusion two years ago." He might live for another 20 years without trouble: he may be dead by now. Employers should place such persons in some supervisory position and not entrust them with the lives of others. It is impossible to avoid deaths caused by previously undetectable coronary disorders in drivers. I sympathize with the victim of a severe coronary attack, but he should not be allowed to operate motor vehicles.

Your consultant's closing paragraph recommending development of "a device that would shut off the engine and gradually apply the brakes if the driver suddenly becomes incapacitated" raises an interesting question. If the driver "suddenly becomes incapacitated" when the bus is approaching a sharp turn with a 100 ft. drop-off on the outside of the turn, who or what will turn the wheel and keep the bus from going over the bank?

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TRICHOMONAS VAGINALIS

To the Editor:—*In* The Journal *of May 8, 1954, page 221, is an answer to a question on the possible relationship between Trichomonas vaginalis infections and epididymitis. As you state you are unable to find any reference to it in the literature. I should like to point out that Liston and Lees in an excellent article entitled "Trichomonas Vaginalis Infestation in Male Subjects"* (Brit. J. Ven. Dis. **16**:*34, 1940) wrote, "The development of epididymitis in a man suffering from non-gonococcal urethritis should cause a careful search to be made for Trichomonas Vaginalis." I must confess that my own research on the subject failed to establish any link between the two conditions.*

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CIRCUMCISION

To the Editor:—*In the reply in* The Journal, *Sept. 18, 1954, page 292, to a question about the advisability of circumcising all newborn male infants, it should be noted that the opinion is that of a urologist based on his observations of his own patients. His sample of the male population can hardly be considered representative, since the vast majority of men go through life without ever consulting a urologist. His observations may be valid, but his perspective is necessarily limited.*

As a general practitioner in a rural area where less than 0.3% of the adult males are circumcised, I am impressed with the rarity of any disease that could be honestly blamed on the foreskin. Further, it would appear that the normal prepuce is of advantage to its owner, protecting the sensitivity of the glans and supplying the integument to accommodate penile growth at puberty and enlargement during erection. Its unnecessary removal seems unphysiological. The conviction that the normal foreskin is a nuisance is held exclusively by the circumcised. There have been attempts to rationalize the procedure along many lines. Prior to 1900 a great deal was published about the value of circumcision in the prophylaxis and treatment of masturbation, feeble-mindedness, epilepsy, spastic paralysis, and even diabetes and tuberculosis. More recent essays in this direction have been equally bizarre. A study by Dr. Ernest L. Wynder relates carcinoma of the cervix to uncircumcised husbands. The idea that smegma, the desquamated epithelium of the glans, could have any significant carcinogenic activity seems absurd. Penile cancer is rare in the United States. That any significant amount of this substance is deposited on the cervix during coitus also seems absurd.

John M. Foley, M.D.
Frankford, W. Va.

SITE OF SMALLPOX VACCINATION

To the Editor:—*Regarding the question from Dr. Glen Howard as to the rationale of vaccinating on the back between the scapulas, in* The Journal *of Oct. 16, 1954, page 751, this site is being used in our preschool-age vaccination program here because this is the only spot on the body that cannot be reached by scratching fingers. The children in this group, from 6 months to 6 years of age, do not have the self-control to resist the urge to scratch their vaccinations. Frequently multiple self-vaccinations occur with unnecessary scarring and occasional severe, systemic toxic reactions. It is my opinion, after having observed the outcome of similar programs using the conventional site, that the rate of adverse reactions is less when the back is used. Other variables, however, are the virulence of a particular batch of vaccine and the quantity of the inoculum. I have the nurses use three light corneum punctures, and though the rate of take is poorer the lesions are smaller and there is less scarring. Revaccination of a few children in whom this does not take is less of a problem than facing the parents of a child who is severely ill from a supposedly safe procedure.*

Robert Lee McKinley, M.D.
County Health Officer
Frio County, Pearsall, Texas.

TOMATO JUICE, KIDNEY STONES, AND CANCER OF PROSTATE

To the Editor:—*Certain statements in the consultants' replies on "Tomato Juice and Kidney Stones" and "Cancer of the Prostate," both in* The Journal *for Sept. 18, 1954, page 292, do not conform with the generally accepted conceptions in the field of urology. I would like to make the following suggestions, the first seven of which pertain to the first query mentioned, while the other three pertain to the second query.*

1. The habitual use of calcium carbonate favors the formation of renal calculi not because of the alkalinity but because of the calcium intake. 2. Milk in Sippy diet is recognized as producing hypercalciuria and is the main factor in producing calculi, acid or otherwise, in some patients. 3. Tomato juice free of condiments rarely produces vesical irritation. A small percentage of persons seem to react unfavorably insofar as the bladder is concerned, but this is unusual. Tomato juice does contain oxalates. 4. There are no pure oxalate stones. 5. Calcium oxalate stones do show in roentgenograms. 6. The reason tomato juice is not indicated is because of its oxalate content. 7. Calcium oxalate stones may form in either acid or alkaline urine.

8. Large doses of estrogen do not produce adenomatous growths of the prostate. Estrogens produce metaplasia. 9. Both estrogens and androgens do produce decrease in the size of the prostate in some men when hypertrophy has occurred. Estrogens are the more effective in this respect. 10. From 1893 to 1900, White of Philadelphia castrated patients for benign hypertrophy and observed satisfactory results in 85% of them. There is no evidence that testosterone will initiate cancer of the prostate, although it will stimulate a cancer that already exists. Giving testosterone does more than replace a deficiency. It upsets an established equilibrium in many ways.

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JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, SEPTEMBER-DECEMBER 1954

Abstracts have been made of important articles in the following journals in the Current Medical Literature Department of THE JOURNAL during the past four months. Any of the journals, except those starred, will be lent by the Library of the American Medical Association to individuals in Continental United States and Canada who subscribe to its scientific periodicals and to members of the American Medical Association and its student organization. No charge is made to members, but the fee for other borrowers is 15 cents in stamps for each periodical. Three journals may be borrowed at a time for a period not exceeding five days. Thus most of these journals are accessible to the general practitioner.

*A. M. A. American Journal of Diseases of Children. Chicago.
*A. M. A. Archives of Dermatology and Syphilology. Chicago.
*A. M. A. Archives of Industrial Hygiene and Occupational Medicine. Chicago.
*A. M. A. Archives of Internal Medicine. Chicago.
*A. M. A. Archives of Neurology and Psychiatry. Chicago.
*A. M. A. Archives of Ophthalmology. Chicago.
*A. M. A. Archives of Otolaryngology. Chicago.
*A. M. A. Archives of Pathology. Chicago.
*A. M. A. Archives of Surgery. Chicago.
Acta chirurgica scandinavica. Stockholm.
Acta clinica belgica. Brussels.
Acta haematologica. Basel.
Acta medica scandinavica. Stockholm.
Acta oto-laryngologica. Stockholm.
Acta paediatrica. Uppsala.
Acta radiologica. Stockholm.
Acta tuberculosea belgica. Brussels.
Acta tuberculosea scandinavica. Copenhagen.
American Heart Journal. St. Louis.
American Journal of Clinical Nutrition. New York.
American Journal of Clinical Pathology. Baltimore.
American Journal of Gastroenterology. New York.
American Journal of Hygiene. Baltimore.
American Journal of the Medical Sciences. Philadelphia.
American Journal of Medicine. New York.
American Journal of Obstetrics and Gynecology. St. Louis.
American Journal of Ophthalmology. Chicago.
American Journal of Pathology. Ann Arbor, Mich.
American Journal of Psychiatry. New York.
American Journal of Public Health. New York.
American Journal of Roentgenol. and Radium Therapy. Springfield, Ill.
American Journal of Surgery. New York.
American Journal of Syphilis, Gonor. and Venereal Diseases. St. Louis.
American Journal of Tropical Medicine and Hygiene. Baltimore.
American Practitioner and Digest of Treatment. Philadelphia.
American Review of Tuberculosis. New York.
American Surgeon. Atlanta, Ga.
Anales de la Facultad de medicina de Montevideo. Montevideo.
Anales de la Sociedad de Biología de Bogotá. Bogotá.
Anesthesiology. New York.
Angiology. Baltimore.
Annales d'endocrinologie. Paris.
Annals of Allergy. Minneapolis.
Annals of Internal Medicine. Lancaster, Pa.
Annals of Otology, Rhinology and Laryngology. St. Louis.
Annals of the Rheumatic Diseases. London.
Annals of Surgery. Philadelphia.
Archiv für Dermatologie und Syphilis. Berlin.
Archiv für Geschwulstforschung. Leipzig.
Archiv für klinische Chirurgie. Berlin.
Archives of Disease in Childhood. London.
Archives des maladies del'appareil digestif et des maladies de la nutrition. Paris.
Archives des maladies du coeur et des vaisseaux. Paris.
Archives of Pediatrics. New York.
Archives of Physical Medicine and Rehabilitation. Chicago.
Archivo per le scienze mediche. Turin.
Archivum chirurgicum neerlandicum. Arnhem.
Arizona Medicine. Phoenix.
Arquivos do Departamento de assistência a psicopatas do estado de São Paulo. São Paulo.
Arquivos mineiros de leprologia. Brazil.
Ärztliche Wochenschrift. Berlin.
Australian and New Zealand Journal of Surgery. Melbourne.
Beiträge zur klinischen Chirurgie. Munich.
Beiträge zur Klinik der Tuberkulose. Heidelberg.
Belgisch tijdschrift voor geneeskunde. Leuven.
Blood. New York.
Boletim clínico dos hospitais civis de Lisboa. Lisbon.
Boletín Médico del Hospital Infantil. Mexico, D. F.
Bollettino e memorie della Società Piemontese di chirurgia. Turin.
Brain. London.
British Heart Journal. London.
British Journal of Cancer. London.
British Journal of Industrial Medicine. London.
British Journal of Ophthalmology. London.
British Journal of Physical Medicine. London.
British Journal of Plastic Surgery. Edinburgh.
British Journal of Preventive and Social Medicine. London.
British Journal of Radiology. London.
British Journal of Surgery. Bristol.
British Journal of Venereal Diseases. London.
British Medical Journal. London.
Bulletin of the New York Academy of Medicine. New York.
California Medicine. San Francisco.
Canadian Journal of Public Health. Toronto.
Canadian Medical Association Journal. Montreal.
Cancer. Philadelphia.
Cancer Research. Chicago.
Chinese Medical Journal. Peking.
Chirurg. Berlin.
Cincinnati Journal of Medicine. Cincinnati.
Circulation. New York.
Circulation Research. New York.
Cirugía ginecología y urología. Madrid.
Clinical Science. London.
Connecticut State Medical Journal. New Haven, Conn.
Danish Medical Bulletin. Copenhagen.
Delaware State Medical Journal. Wilmington.
Deutsche medizinische Wochenschrift. Stuttgart.
Deutsches medizinisches Journal. Berlin.
Deutsche Zeitschrift für Nervenheilkunde. Berlin.
Diabetes. New York.
Die Medizinische. Stuttgart.
Diseases of Chest. Chicago.
East African Medical Journal. Nairobi.
Edinburgh Medical Journal. Edinburgh.
Electroencephalography and Clinical Neurophysiology. Montreal.
Fertility and Sterility. New York.
Fortschritte auf dem Gebiete der Röntgenstrahlen vereinigt mit Röntgenpraxis. Stuttgart.
Gastroenterology. Baltimore.
Gazeta médica portuguesa. Lisbon.
Gazzetta medica italiana. Milan.
Geriatrics. Minneapolis.
Giornale di clinica medica. Parma.
Giornale di gerontologia. Florence.
Glasgow Medical Journal. Glasgow.
GP (Journal of American Academy of General Practice). Kansas City, Mo.
Harefuah. Jerusalem.
Hawaii Medical Journal. Honolulu.
Helvetica paediatrica acta. Basel.
Illinois Medical Journal. Chicago.
Industrial Medicine and Surgery. Chicago.
International Journal of Leprosy. New Orleans.
Journal of Allergy. St. Louis.
Journal of the American Geriatrics Society. Baltimore.
Journal of the American Medical Woman's Association. New York.
Journal of Applied Physiology. Washington, D. C.
Journal of Aviation Medicine. St. Paul.
Journal of Bone and Joint Surgery. Boston and London.
Journal de chirurgie. Paris.
Journal of Clinical Endocrinology and Metabolism. Springfield, Ill.
Journal of Clinical Investigation. New York.
Journal of Clinical Pathology. London.
Journal of Endocrinology. London.
Journal of Experimental Medicine. New York.
Journal of the Florida Medical Association. Jacksonville.
Journal of Immunology. Baltimore.
Journal of Indian Medical Association. Calcutta.
Journal of the Indiana State Medical Association. Indianapolis.
Journal of International College of Surgeons. Chicago.
Journal of Investigative Dermatology. Baltimore.
Journal of the Iowa State Medical Society. Des Moines.
Journal of the Irish Medical Association. Dublin.
Journal of the Kansas Medical Society. Topeka.
Journal of the Kentucky State Medical Association. Bowling Green.
Journal of Laboratory and Clinical Medicine. St. Louis.
Journal of Laryngology and Otology. London.
Journal of the Maine Medical Association. Portland.
Journal de médecine de Lyon. Lyon.
Journal of the Medical Association of the State of Alabama. Montgomery.
Journal of the Medical Association of Georgia. Atlanta.
Journal of the Medical Society of New Jersey. Trenton.
Journal of Mental Science. London.

* Cannot be lent.

Journal of the Michigan State Medical Society. Lansing.
Journal of the National Medical Association. New York.
Journal of Nervous and Mental Disease. New York.
Journal of Neurology, Neurosurgery and Psychiatry. London.
Journal of Neuropathology and Experimental Neurology. New York.
Journal of Neurosurgery. Springfield, Ill.
Journal of Nutrition. Philadelphia.
Journal of Pathology and Bacteriology. Edinburgh.
Journal of Pediatrics. St. Louis.
Journal of Pharmacology and Experimental Therapeutics. Baltimore.
Journal of the South Carolina Medical Association. Florence.
Journal of the Tennessee State Medical Association. Nashville.
Journal of Thoracic Surgery. St. Louis.
Journal of Urology. Baltimore.
Journal-Lancet. Minneapolis.
Klinische Monatsblätter für Augenheilkunde. Stuttgart.
Klinische Wochenschrift. Berlin.
Lancet. London.
Laryngoscope. St. Louis.
Leprosy Review. London.
Louisiana State Medical Society Journal. New Orleans.
Lyon chirurgical. Paris.
Maandschrift voor kindergeneeskunde. Leiden.
Manitoba Medical Review. Winnipeg.
Maryland State Medical Journal. Baltimore.
Medical Annals of the District of Columbia. Washington.
Medical Journal of Australia. Sydney.
Medicina colonial. Madrid.
Military Surgeon. Washington, D. C.
Minerva chirurgica. Turin.
Minerva dermatologica. Turin.
Minerva ginecologica. Turin.
Minerva medica. Turin.
Minerva pediatrica. Turin.
Minnesota Medicine. St. Paul.
Missouri Medicine. St. Louis.
Monatsschrift für Kinderheilkunde. Berlin.
Monatsschrift für Unfallheilkunde und Versicherungsmedizin. Berlin.
Münchener medizinische Wochenschrift. Munich.
Nederlandsch tijdschrift voor geneeskunde. Amsterdam.
Neurology. Minneapolis.
New England Journal of Medicine. Boston.
New York State Journal of Medicine. New York.
New Zealand Medical Journal. Wellington.
Nordisk medicin. Stockholm
Northwest Medicine. Seattle.
Obstetrics and Gynecology. New York.
Pediatrics. Springfield, Ill.
Pédiatrie. Lyon.
Pennsylvania Medical Journal. Harrisburg.
Plastic & Reconstructive Surgery. Baltimore.
Policlinico (Practical Section). Rome.
Postgraduate Medical Journal. London.
Postgraduate Medicine. Minneapolis.
Presse médicale. Paris.
Proceedings of Royal Society of Medicine. London.
Proceedings of the Society for Experimental Biology and Medicine. Utica, N. Y.
Proceedings of Staff Meetings of Mayo Clinic. Rochester, Minn.
Progresso medico. Naples.
Quarterly Journal of Medicine. Oxford.
Quarterly Journal of Studies on Alcohol. New Haven, Conn.
Radiology. Syracuse, N. Y.
Revista de la Asociación médica argentina. Buenos Aires.
Revista da Associação médica brasileira. São Paulo.
Revista brasileira de tuberculose. Rio de Janeiro.
Revista chilena de pediatría. Santiago.
Revista de investigación clínica. Mexico, D. F.
Revista paulista de medicina. São Paulo.
Révue de la tuberculose. Paris.
Riforma medica. Naples.
Rivista di ostetricia e ginecologia pratica. Milan.
Rivista di patologia e clinica della tubercolosi. Bologna.
Rocky Mountain Medical Journal. Denver.
Schweizerische medizinische Wochenschrift. Basel.
Semaine des hôpitaux de Paris. Paris.
Semana médica. Buenos Aires.
Settimana medica. Florence.
South African Journal of Clinical Science. Cape Town.
South African Medical Journal. Cape Town.
South Dakota Journal of Medicine and Pharmacy. Sioux Falls.
Southern Medical Journal. Birmingham, Ala.
Surgery. St. Louis.
Surgery, Gynecology and Obstetrics. Chicago.
Thorax. London.
Thoraxchirurgie. Stuttgart.
Tidsskift for den norske lægeforening. Oslo.
Tórax. Montevideo.
Tubercle. London.
Ugeskrift for læger. Copenhagen.
Ulster Medical Journal. Belfast.
United States Armed Forces Medical Journal. Washington, D. C.
Virchows Archiv für pathologische Anatomie und Physiologie. Berlin.
Virginia Medical Monthly. Richmond.
West Virginia Medical Journal. Charleston.
Western Journal of Surgery, Obstetrics and Gynecology. Portland, Ore.
Wiener klinische Wochenschrift. Vienna.
Wiener medizinische Wochenschrift. Vienna.
Wisconsin Medical Journal. Madison.
Yale Journal of Biology and Medicine. New Haven.
Zeitschrift für Kinderheilkunde. Berlin.
Zentralblatt für Gynäkologie. Leipzig.

SUBJECT INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "C," Correspondence; "ab," abstracts; the asterisk (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

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Acad.—Academy	*Indust.—Industrial*
Am.—American	*Inst.—Institute*
A.—Association	*Internat.—International*
Coll.—College	*M.—Medical*
Comm.—Commission	*Med.—Medicine*
Comm.—Committee	*Nat.—National*
Conf.—Conference	*Pharm.—Pharmaceutical*
Cong.—Congress	*Phys.—Physicians*
Dist.—District	*Soc.—Society*
Div.—Division	*Surg.—Surgery*
Found.—Foundation	*Surgs.—Surgeons*
Hosp.—Hospital	*S.—Surgical*

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The Irritable Colon

THE IRRITABLE COLON syndrome has been called a colonic neurosis, for the bowel is not diseased — it is the emotions that are in turmoil. But labeling a disorder "psychosomatic" does not make it disappear. The manifestations of the irritable colon are troublesome to patient and doctor alike. The disorder is indeed a common one, its incidence being variously reported as ranging from 18 to 50 per cent of all gastrointestinal disturbances.

The diagnosis suggests itself when a middle-aged patient complains of lower abdominal pain, constipation or diarrhea and shows what has been called evidence of a labile autonomic nervous system: dermographia and flushing; much dryness or oiliness of the skin; cold, wet hands; tachycardia, bradycardia or hypotension.

The pain, though usually in the left lower quadrant, may occur in any part of the abdomen. It tends to shift, and it may be sharp, dull, intermittent, cramplike, mild or severe. It can mimic an acute abdominal condition and has led to a variety of surgical procedures, most often appendectomy. The pain is evidently caused by distention of the bowel with gas or by vigorous and excessive peristalsis. Ingestion of food or drink increases the pain; defecation, an enema or the passage of flatus may relieve it.

Constipation, Diarrhea or Both

Constipation was formerly considered characteristic of the irritable colon or the spastic colon. Now it is clear that either constipation or diarrhea may be present, and they may alternate and thus raise the question of carcinoma of the colon. Often pencil- or ribbon-like stools will contribute to this impression. The stools in some patients may be watery, mushy, or thin and fragmented. Or small, hard, scybalous pellets are defecated in the morning and followed shortly by diarrhea. Usually, the stools are not bloody, grossly or microscopically. Mucus may be present in the stool, and when the amounts are regularly large, there comes to mind not only a disorder of motor activity, but also irritability and increased secretory activity of the goblet cells of the colon. This state of affairs is called "mucous colitis" though it is only a variation of the irritable colon syndrome and not a different disease. Despite the diarrhea, there is rarely weight loss or impaired nutrition.

Thomas P. Almy (New York Hospital—Cornell Medical Center) has studied patients with the irritable colon syndrome manifested chiefly by spastic constipation and has employed a latex balloon to record motility of the colon kymographically. He describes these patients as tense and hostile. The proximal colon was often dilated and filled with gas. On proctosigmoidoscopy, the lumen of the sigmoid was frequently occluded by spasm. There was increased wavelike motility of the sigmoid colon, which was nonetheless shown with tandem balloons to be ineffective for propulsion. Almy's own view is that these are "holding back" contractions in an effort to retain feces.

The patient with functional diarrhea Almy describes as usually soft-spoken with a superficial attitude of guilt and a countercurrent of deep resentment and a sense of inadequacy in dealing with his problems. The behavior pattern symbolizes hopelessness or defeat, according to Almy, and is reflected in a diminution of

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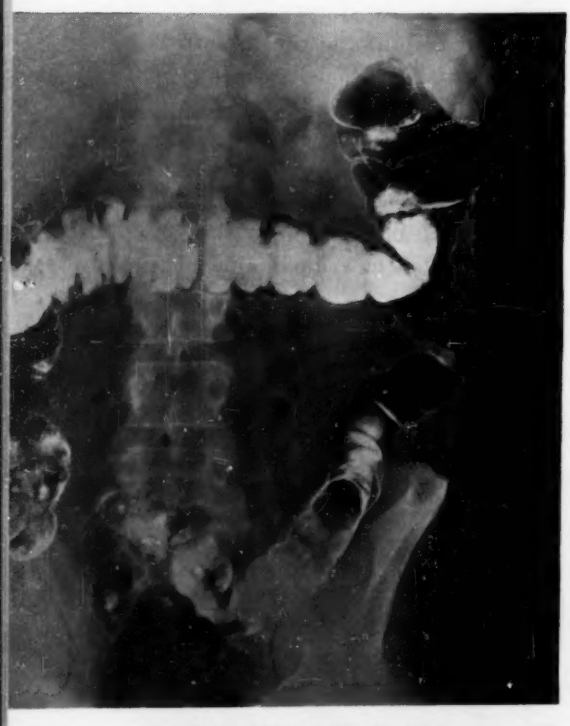
Roentgen film after barium enema reveals spasm of the distal colon, which usually is present when the irritable colon syndrome is manifested by constipation. A tender, sausage-shaped tube can frequently be palpated on the left side.



When the splenic flexure syndrome is present, roentgen film shows the splenic flexure of the colon trapping gas and feces. This causes pressure on the diaphragm, which results in left upper quadrant pain and also coronary-like pain.

segmental contractions in the sigmoid colon, the lumen of which was usually wide open rather than occluded. As a result, there is an increased gradient of motility between the proximal and distal colon, permitting the ready passage of feces.

W. J. Grace (New York Hospital–Cornell Medical Center) and D. T. Graham (Washington University School of Medicine, St. Louis) relate diarrhea to a desire to be alone or to get rid of something or somebody; they ascribe constipation to a grim resolve to carry on even when confronted with an insoluble problem — a phenomenon of holding on without change. J. Weiss (Mount Zion Hospital, San Francisco) has associated mucous colitis with what he calls "anal aggressive trends" and, like many other investigators, has been interested in uncovering toilet-training conflicts in childhood.

Dyspepsia frequently accompanies other commotion in the abdomen. The patient may complain of fullness and abdominal distention after meals, with nausea, belching and flatulence. An excess of gas is noted in the stomach on percussion and on fluoroscopy. There is usually irritability of the entire gastrointestinal tract, but the predominant symptoms relate to the large bowel.

Physical examination may disclose a palpable, narrow, tender, sausage-shaped tube on the left side of the abdomen. Increased peristalsis may be seen and felt, and borborygmi heard. On proctosigmoidoscopy, there may be sufficient irritability and spasm at the rectosigmoid junction to make it impossible to pass the instrument beyond the rectum. The procedure often provokes abdominal pain similar to that which the patient has spontaneously. The mucosa of the rectum and sigmoid colon may be engorged and covered with mucous strands.

Roentgenographic examination of the colon by means of a barium enema may disclose rapid filling, narrowing, and segmental or zonal spasm, especially in the region of the sigmoid colon. The left colon is much more commonly involved than the right. A "string sign" involving the descending colon may be observed.

Roentgenologists usually regard spasm in the left colon as more likely to be functional in origin, whereas spasm of the right colon is more often associated with organic disease, such as carcinoma, tuberculosis or ulcerative colitis. At times the roentgenographic findings may be entirely normal.

T. E. Machella, H. J. Dworken and F. J. Biel (reporting from the Hospital of the University of Pennsylvania, Philadelphia) have recently described a splenic flexure syndrome, associated with the irritable colon, which gives rise to pain and discomfort not only in the left upper quadrant but also in areas to which coronary pain is usually referred. The splenic flexure, because of its anatomic position, acts as a trap for the collection of gas or feces when spasm is present; this pressure against the left diaphragm causes the coronary-like pain. Machella and his collaborators demonstrated considerable amounts of gas in the splenic flexure while the patient was having symptoms. They have also distended the splenic flexure by inflating a balloon introduced through the rectum and thus have reproduced the symptoms.

Although diagnosis of irritable colon is suggested by the characteristic constellation of symptoms — abdominal distress, constipation or diarrhea, cold, wet hands, etc. — organic disease must always be carefully excluded by means of digital examination of the rectum, fecal analysis, proctosigmoidoscopy and the barium enema.

Management

In management one must make some approach to the tension state that is responsible for the syndrome. The disorder has been termed "caught-in-a-trap disease," and for a patient in the trap, psychotherapy

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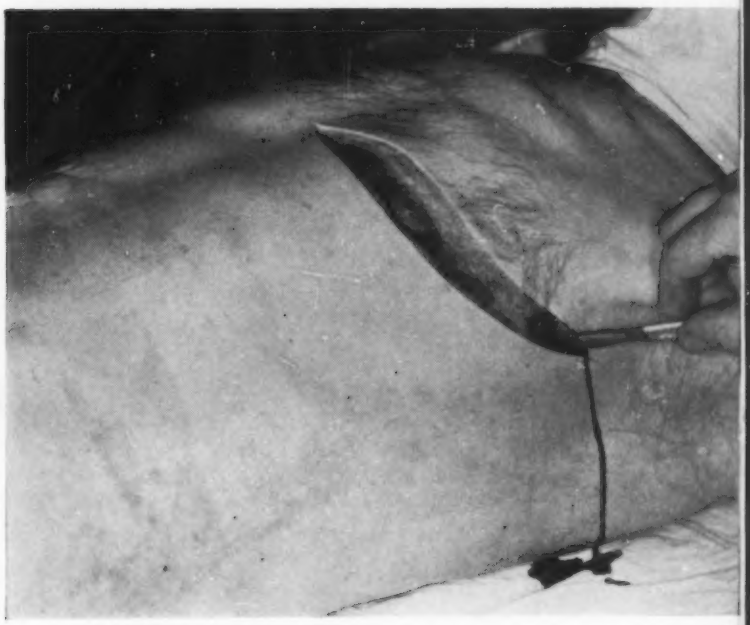
Four Minutes To Go



When no pulse is felt nor blood pressure obtained, diagnosis of cardiac arrest is made. Time is not lost confirming the evidence or "deciding" what steps to take. The chest wall is opened forthwith. Without waiting for drapes or gloves, incision is made in the fourth left intercostal space lateral to the mammary vessels.

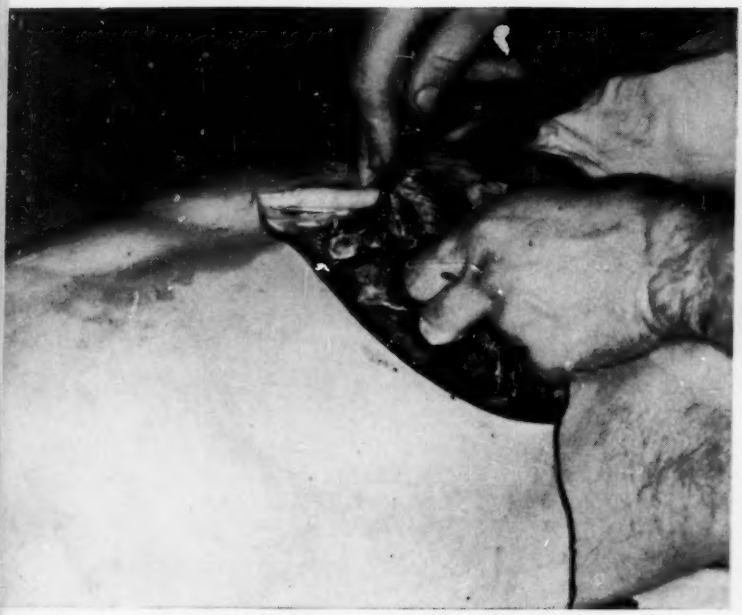
IN CARDIAC ARREST one is generally said to have no longer than 4 minutes (some say only 3) to get a supply of oxygenated blood to the brain and keep it going there. This means opening the chest, working the heart by hand and forcing straight oxygen into the lungs by endotracheal tube. Often it also means, unfortunately, deciding that the heart has actually stopped, finding someone forthright enough to start cutting the chest wall, assembling an endotracheal tube (or finding an anesthesiologist who knows where there is one) and attending to several other particulars, culminating in an autopsy or, conceivably worse, a living patient who has to be fed, dressed, helped to walk and conjectured about for some time afterward while everyone waits for cerebral function to "return."

Of all the catastrophes that ensue upon cardiac arrest, then, the most regrettable one is hesitation. In most cases, about 85 per cent, the heart stops in the operating room, and the diagnosis can be established by direct vision within seconds. Yet there may be hesitation, in part from sheer incredulity and perhaps, for many, from unfamiliarity with a procedure that seems a little heroic.

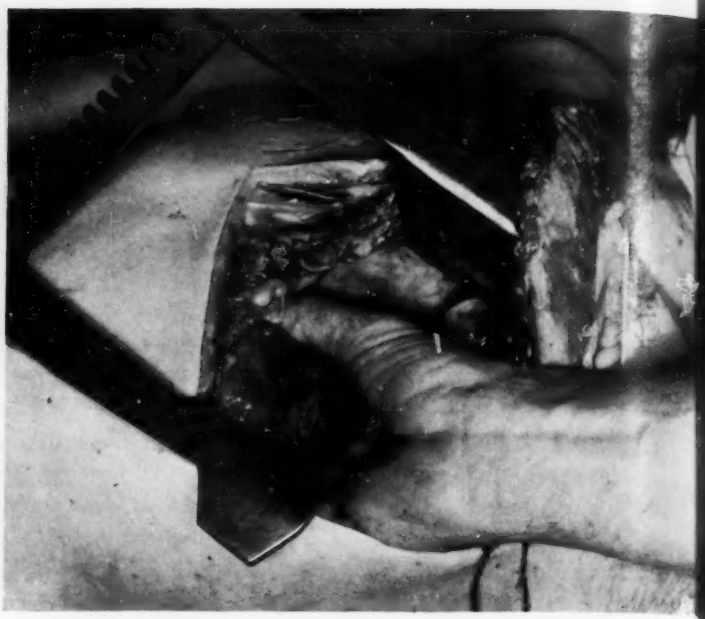
The procedure is very straightforward. If the thoracic cavity is not open, the physician divides the chest wall with a knife, a bandage scissors, or whatever is handy (sometimes without benefit of gloves) and reaches the heart through the fourth intercostal space. Holding it usually in one hand, he compresses it rhythmically while someone else sees to the oxygen. (Regrettably the term "cardiac massage" has been used for this effort. It is not massage; it is application of a force for contraction, as by the hand compressing the heart.) As long as this can be done, the patient is alive and his cerebrum can function. But it is hard work; no one can do it for more than 2 or 3 minutes.

Standstill or Fibrillation

While this is going on and cerebral hypoxia is relieved, it becomes of moment to learn what state the heart is in and whether it can be prompted to take up its own work. With the hand alone one can discern whether the heart is in complete standstill or is fibrillating (when it feels like a "bag of worms"); if the pericardium is opened, one can see this directly. It may be that, if the heart was originally in standstill, it has resumed rhythmic contractions in response to manual compression alone; if not, it can be stimulated, the agent most frequently used being epinephrine either applied to the surface or injected into the right ventricle. If the heart is fibrillating, an atrial injection of procaine followed, if necessary, by electric shocks from a defibrillator will generally reduce its irritation sufficiently to bring it to standstill and end the useless rippling of the myocardial fibers. Rhythmic systoles may then return spontaneously, or normal action



In as few seconds as possible, incision is extended medially and costal cartilages are cut. An adequate opening facilitates manual compression and also prevents trauma to the heart. While incision is being completed, steps are taken to provide full and uninterrupted ventilation of the lungs with straight oxygen.



If a self-retaining retractor is not at hand, the ribs can be pulled apart manually and "massage" begun. With the retractor providing greatest maneuverability, the heart is grasped and compressed with a flat-handed milking motion, shifting the blood from apex to base. Pressure is rhythmically relaxed to allow refilling.

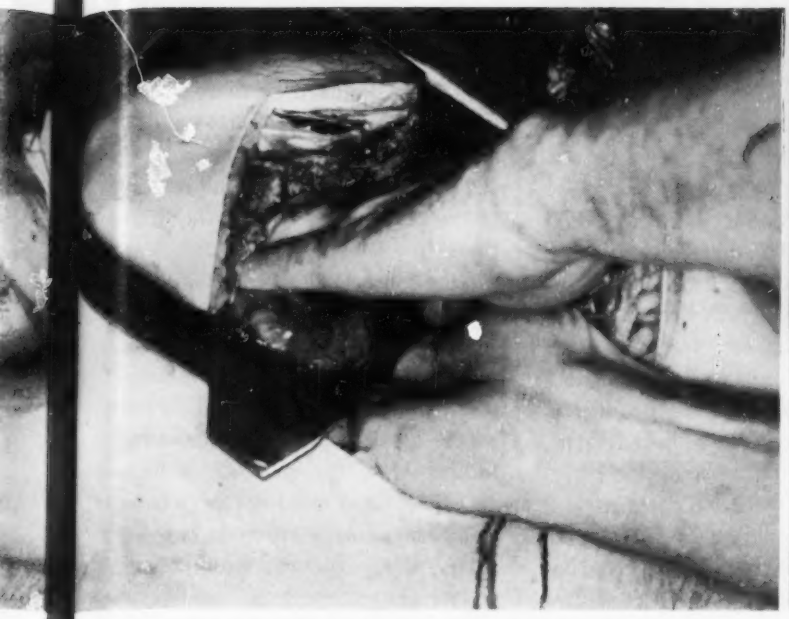
may have to be induced by sustained massage or perhaps (if fibrillation recurs) by further procaine injection or electric defibrillation. Here the use of epinephrine, which may cause such renewed fibrillation, is naturally avoided.

A simple electric defibrillator can be put together on the spot; if there is nothing better, a lamp cord hitched to a pair of metal retractors will do. Swift plugging and unplugging of this emergency contraption into the conventional 110-volt, 60-cycle A.C. socket always shocks the ventricle and sometimes induces standstill or immediate resumption of natural systole. However, besides being somewhat risky for the operator, such rough and ready defibrillation is not without hazard to the patient, the chief danger being thermal damage to the heart at the points of contact. Use of a proper defibrillator minimizes or completely avoids such "burning." Current flow is limited and standardized, and adequate electrodes, saturated with saline, equalize density in all areas. One such device, designed by Mr. E. L. Birkmire of Philadelphia, is described on the basis of microscopic examination of myocardial tissue as being so constructed as totally to avoid thermal damage after intermittent shock periods totaling several seconds.

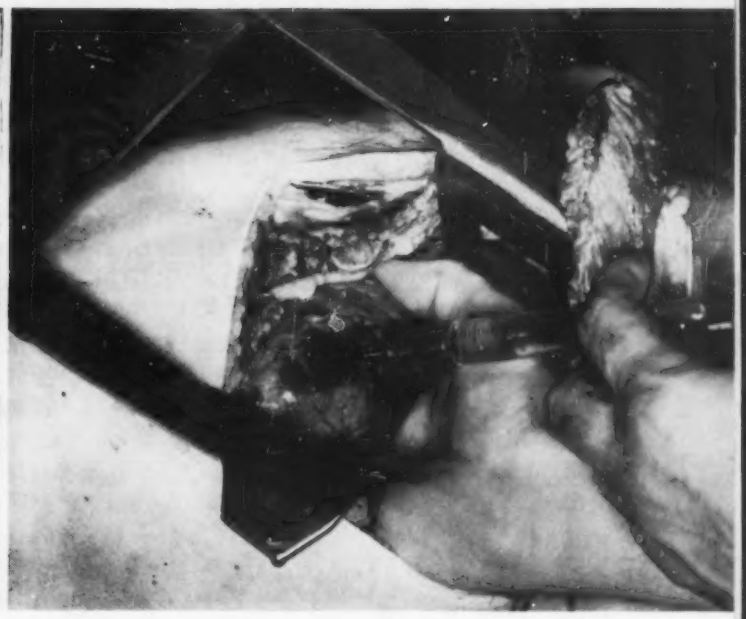
The profession and the public alike were recently startled by the reported doings of an electric pacemaker acting upon an arrested heart through the intact chest. In a case described by Paul M. Zoll (Harvard Medical School) in which spontaneous beating was restored by this technique, normal cardiac rhythm and circulation had been maintained for 50-odd hours without the heart's having originated a single beat on its own. However noteworthy this accomplishment, there is doubt that an anoxic heart will respond to external stimulation, and for the time being the procedure continues to be thoracotomy, massage and, when necessary, further treatment of standstill or fibrillation.

Incidence

Cardiac arrest occurs in from 1 in 5,000 to 1 in 1,000 anesthesias; there is disagreement about just how often it occurs, but the higher incidence is more favored. There is also disagreement about whether there is more than there used to be, or whether the physician is becoming more alert in the operating room. H. E. Stephenson, Jr. (University of Missouri School of Medicine, Columbia), L. C. Reid and J. W. Hinton (Post-Graduate Medical School, New York University) believe that the increase is real and that probable causes include complex systems of medication and anesthesia, together with instrumentation such as the endotracheal tube, bronchoscope and cardiac catheter. Hypoxia during anesthesia is a recognized factor. Seymour Schotz at the Presbyterian Hospital in Philadelphia rejects "a tendency in some quarters to indict certain anesthetic drugs or techniques," for he contends that "skillful anesthetic management with a thorough knowledge of the particular drugs and techniques used would probably eliminate a good many cardiac arrests."



When the heart is uncommonly large, proper compression can be secured by using 2 hands, 1 in front and 1 behind. Recommended rates of compression vary from 50 to 100 per minute, the object being to maintain a vigorous circulation, to approximate the normal rhythm and to minimize fatigue to the operator.



Once effective oxygen transport has been secured, various means are used to restore spontaneous heartbeat. In standstill, manual systole alone often suffices. When the myocardium remains flabby and requires chemical stimulation, epinephrine can be injected into the cavity of the right atrium or the right ventricle.

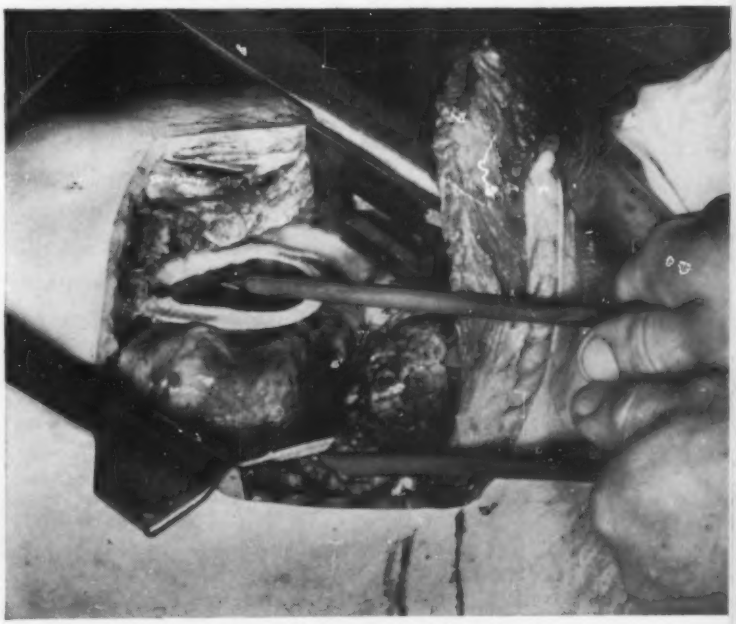
The fault, he implies, is not to be found in the bottles.

The regrettable fact is that sometimes it becomes finally evident that the heart has stopped for good. When this happens it is probably for one of the following reasons, according to Claude S. Beck (Western Reserve University School of Medicine): resuscitation was begun too late; the lungs were inadequately ventilated; satisfactory circulation was not maintained; carbon dioxide was not absorbed (in a closed gas system); or, finally, intrinsic heart disease precluded resuscitation. With the exception of the last, all these can be circumvented.

The time to prepare against cardiac arrest is obviously before it occurs. Emergency mobile units can be kept at hand in operating rooms and elsewhere in the hospital, stocked with drugs and equipment. But more crucial are the trained staff and the requisite frame of mind to use these resources, and for this "fire drills" can be carried out in which everyone has a definite, prearranged responsibility. It is perhaps not cardiac arrest alone but "therapeutic paralysis" that leads to misfortune.

Beck has written, "Many surgeons believe they understand resuscitation. Indeed, some have written papers on the subject. Yet, when it comes time for application of the procedure, there is hesitation, confusion, and failure to understand what the precise nature of the emergency act is." He urges that cadavers and dogs be used for practice. But not only the surgeon — everyone on the staff down to the nurse who reads the oxygen gauge — ought to be constantly on the alert. END

The fibrillating heart rarely resumes natural action by dint of manual systole alone. Sometimes myocardial irritability is reduced by atrial injection of procaine. Usually the twitching cardiac muscle fibers must first be shocked into standstill by an electric defibrillator, following which there may be an immediate resumption of spontaneous beating. If this does not occur, further manual compression may be necessary. If the heart reverts to fibrillation, defibrillating electric shock is again applied. Since the fibrillation itself is a burden upon the heart's own severely reduced oxygen supply and also decreases the effectiveness of manual compression, its elimination is considered to be a matter of extreme urgency.



The Monitoring of Biologicals

WITH DISCUSSION still simmering about the real value of cold vaccines, and poliomyelitis being approached from one and another new direction, it is evident that biologicals (even if antibiotics have greatly overshadowed them) remain a lively part of therapeutics. Producing them too is a livelier enterprise than it might seem.

A Horse and a Few Oats . . .

What looks like the easiest occupation in the world is to buy or rent a horse, inject an antigen, and sit back and wait while the horse does the manufacturing. A few weeks later you put the serum into bottles and send them to a pharmacy. All that is needed is a few oats, for the horse.

But before a practicing physician is willing to inject that serum into his patient, he expects assurance that the material is exactly what it is supposed to be, exactly as potent as intended, sterile beyond a shadow of doubt, pure as it can be and in every other respect perfectly safe. That man with the rented horse has much more to do than sit back and tend the horse; in fact he has a great deal of work cut out for him. There are alert and competent monitoring agencies to see that he does it. Who they are and what they do should be of interest to the physician who relies on them.

No one can lawfully bring a serum, antitoxin, virus, etc., for human use into federal commerce unless his factory is licensed and his product is suitably labeled. The so-called Virus, Serum and Toxin Act of 1944 (reenacted from 1902) so declares, and regulations issued by the U.S. Public Health Service explain exactly what is required by way of licensing and labeling. A plant, to be licensed, must have a well-qualified and fully responsible man at its head; there must be records and records; the selection and treatment of production animals are fully detailed. Then *each product* must be licensed in its own right as having a desired (or sometimes a minimum) potency, as having an absolutely specific identity, as being demonstrably safe in test animals, as being sterile and pure. That man with the horse, instead of chewing idly on a wisp of hay and trying to recall if he gave the injection a week ago Tuesday or 2 weeks ago Friday, would do better to take the horse back to its owner.

Finally, the product has to bear a label showing what it is and who made it, his license number, the lot number of the material, and, if it has one, the expiration date. Minimum potency of the product in terms of the official standard (if there is one) must be stated. If no official standard has been set, then this must be so stated on the label. In some relation to the package there must be directions for use — on the outer wrapping, or in a leaflet packed with the vial, or wherever such a thing might fit — but as in the case of all medicinal products in interstate commerce, these directions are technically a part of the label; if they are misleading in any way, the product is "misbranded" and subject to seizure, damnation and destruction. No, definitely, the horse was better left in his stable.

Helpful Guidance

Whereas many febrile workings of the government and its agencies are an irritation and an impediment, and some are ominous, the supervision of medicinal products has quite another character. Responsible manufacturers are, if anything, grateful for the detailed guidance afforded them by the National Microbiological Institute of the National Institutes of Health (of the U.S. Public Health Service), charged with making the rules. The men involved are not politicians or "bureaucrats"; they are able, serious scientists, no different at all from the fellows on the manufacturer's staff, with no ax to grind or partiality or prejudice to exercise. They may be as perplexed

over the standardization of gnat serum as anyone else and willing to agree on a tentative standard until matters are cleared up. Or they may know some better titration and are only too happy to suggest it. Or they may be glad to learn of one.

The philosophy behind this truly gifted legislation seems to be: some matters are just too deep for lawyers — better let the scientists figure them out. As a result, the government is placed in the role of an associate or a colleague rather than a policeman; the Public Health Service has always been primarily a group of physicians, biologists, bacteriologists and other thoughtful men who would like to see better therapeutics. Thus there is no real conflict of motives between the U.S. Public Health Service and the producer of a remedy worth while.

Perhaps this is not astonishing in a day when pharmaceutical products are of consistently high grade; but at least older physicians can remember a time when biologicals were one of the darker mysteries. Owing to the present control laws and the enforcement of these laws, that time has passed. END

Pfizer HORMONE newsletter

Complete relief of anal pruritis with hydrocortisone—"Hydrocortisone acetate is truly worthy of the title 'miracle drug'" in pruritus ani, in the opinion of G. L. Becker [*American Journal of Surgery 88*: 289 (Aug.) 1954]. He treated 160 patients with chronic idiopathic disease resistant to previous treatment. Complete relief of symptoms was obtained in 110 cases within 1 week (usually 24–48 hours), partial relief in 29 cases. Ointment containing 1% hydrocortisone was applied twice daily until itching stopped, daily thereafter. "No contraindications have been found for the topical use of hydrocortisone acetate."

— Hormone Newsletter, September, 1954

Seen & Heard

Reports in the news

Lung Biopsy during Mitral Valvulotomy

London, England — The presence of fibrosis in biopsy specimens of the lung portends that elevated pulmonary artery pressures are unlikely to return to normal even after a satisfactory valvulotomy, says Vincent J. McGovern. He has correlated histologic findings in 61 cases with the clinical course following valvulotomy. The specimens of lung tissue were obtained from the lingula of the left lung at operation. Apart from vascular changes and hemosiderosis, 3 grades of focal changes are observed in the lung parenchyma. These include:

- minor foci of fibrinoid thickening of alveolar septa with reduction in the lumen of capillaries,
- more marked fibrinoid change associated with prominence of alveolar lining cells, some mononuclear infiltration and (in some cases) fibrosis,
- a more acute pneumonitis with foci of alveolar exudate consisting of fibrin and polymorphonuclear leukocytes, with fibrosis.

The lung changes are nonspecific and cannot be correlated with the presence of active rheumatic inflammation in the left auricular appendage. McGovern believes they are a reaction to pressure, since they can be found in other conditions in which there is pulmonary hypertension as well as in mitral stenosis.

(Reported at the International Congress of Clinical Pathology, Washington, D.C.)

Tanned Erythrocytes to Detect Platelet Antibodies

Aarhus, Denmark — A new method to demonstrate platelet antibodies is described by F. Kissmeyer-Nielsen. Human erythrocytes are first treated with tannic acid and then incubated with a saline extract of platelets, which coats the erythrocytes. A saline suspension of these antigen-coated, "tanned" red cells is then incubated with the serum to be investigated for

In SPECTRUM Next Week

The Failing Heart – *Understanding the mechanisms of congestive failure is a prime requisite in therapy, as this comprehensive piece points out.*

Cyanosis – *A schematic representation of the mechanisms involved.*

Also: **Boylston, the Brave Physician.**

platelet antibodies, and the results are read as a hemagglutination test. The Danish hematologist reports that the method is specific and 100 times as sensitive as the direct platelet agglutination technique.

(Reported at the 5th International Congress of Hematology, Paris.)

Polycystic Liver

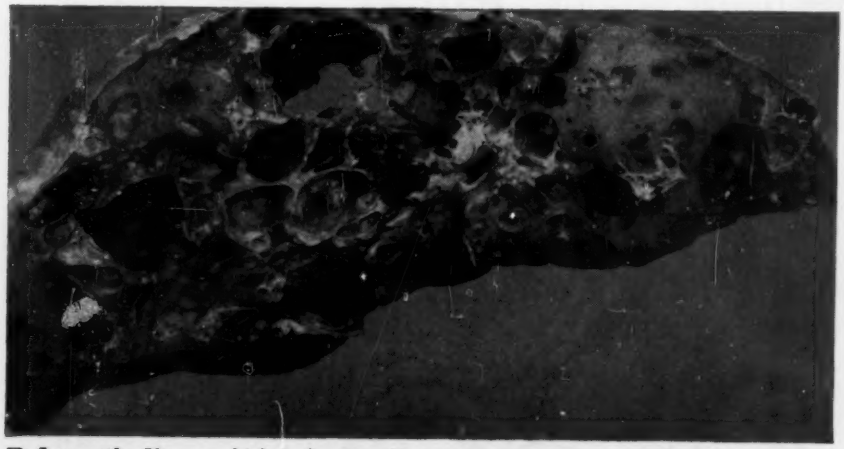
Detroit – A frequent, silent concomitant of polycystic disease of the kidneys is polycystic liver, reports P. J. Melnick (pathologist, now at Wayne County General Hospital). His survey of autopsy records of the past 36 years at the Los Angeles County General Hospital turned up 70 examples, or 1 per 687 autopsies. The disorder has morphologic rather than clinical interest, for in no patient was there distinct evidence of liver dysfunction. The condition is increasingly frequent with advancing age; it results from a gradual cystic dilatation of groups of persisting intralobular bile ducts that fail to involute in the later embryology of the liver. Two of the cases were rare in that new intralobular bile ducts were being formed from liver cell cords. The liver parenchyma in general, as well as the gallbladder and extrahepatic bile ducts, is normal. Congenital anomalies, such as intracranial aneurysm, were associated in a number of the cases.

(Reported at a meeting of the American Medical Association, San Francisco.)

Cardiopathies in the Newborn

Zurich, Switzerland – Although interest in heart disease in infancy has centered on congenital malformations, E. Rossi (Children's Hospital, Zurich) emphasizes that there are a number of myocardoses of the newborn that may lead to cardiac enlargement. Among these he cites glycogenic cardiomegaly, which may occur as an isolated finding, in hemolytic neonatal disorders or in children of diabetic mothers. Disorders of lipid, protein and electrolyte metabolism, as well, may lead to cardiac enlargement in infancy. Nutritional disorders in the newborn may be accompanied by endocardial fibroelastosis. Rossi also points out that an acute cor pulmonale may result from atelectasis or aspiration pneumonia.

(Reported at the International Congress of Gynecology and Obstetrics, Geneva.) END



Polycystic liver, **which is functionally benign despite gross structural abnormality.**

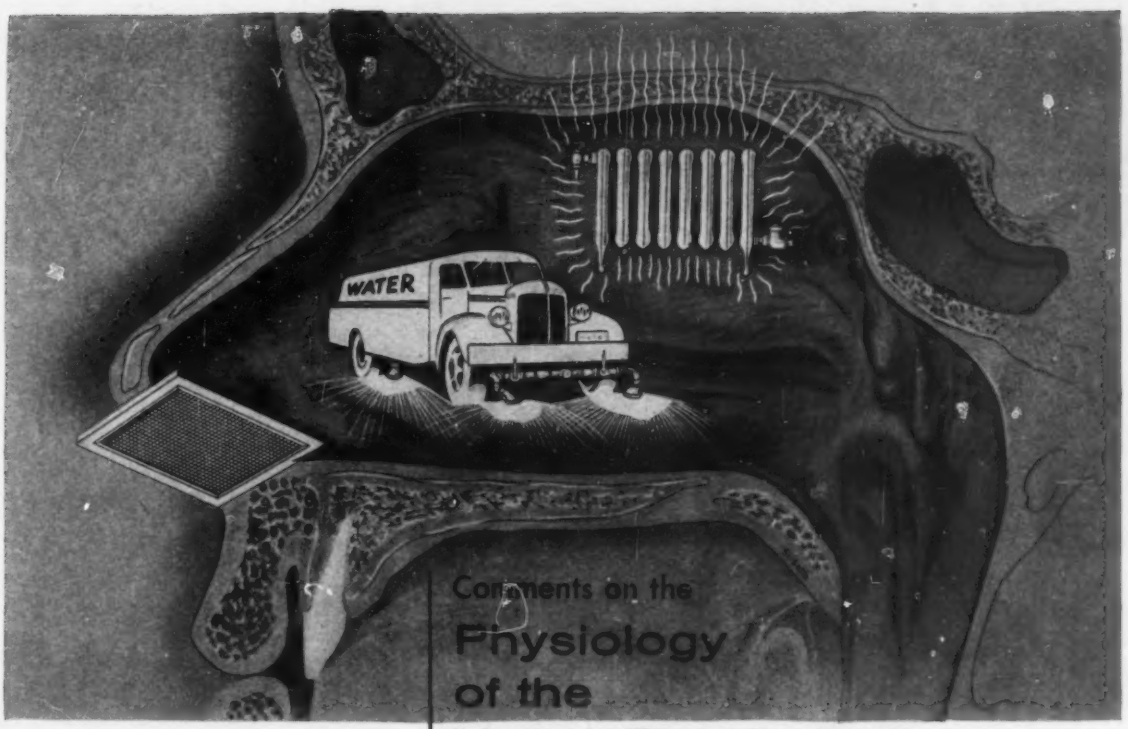
THE IRRITABLE COLON

continued from page 22

may substitute emotional catharsis for the intestinal catharsis or diarrhea. The physician may thus produce relaxation sufficient for the relief of spasm causing the pain and constipation. An understanding approach to an anxious patient is important, with inquiry into the domestic, business, social and economic conflicts that beset him. The salesman with domestic difficulties who declares that his symptoms disappear when he hits the road hardly needs an exploration of infantile anal eroticism or of faulty toilet training. Other patients may need reassurance with regard to fears of cancer or other organic ailments that thorough study has proved unfounded.

Control of the diet is important; the low threshold of irritability in these patients results in increased bowel sensitivity to the less digestible foods such as fried, fatty and spicy foods, raw fruits and raw vegetables. The diet should be bland and leave a low residue. Alcohol is a potent irritant, often precipitating distressing symptoms, and should generally be avoided. Rest, abdominal massage, tepid baths and the time-honored turpentine stupe during acute episodes may give relief. Mild sedation in the form of phenobarbital is often useful. Many patients are helped by such antispasmodics as tincture of belladonna given in increasing doses until 1 to 2 cc. are taken before each meal. Patients with diarrhea have sometimes been helped by anticholinergic drugs.

A philosophic attitude should be cultivated in the sufferer so that he may learn to live with his chronic ailment. It is often more difficult for a patient to make peace with the disability of the bowel than with a cardiac disorder. Many patients prefer to dine and drink as they please – and suffer the consequences. Not only discipline but encouragement, solace, interest and ingenuity on the part of the physician may be needed in the care of such patients. END



Comments on the

Physiology of the Upper Respiratory Tract

THE NASAL CAVITY:

The main functions of the nasal cavity are conditioning and exchanging air between the atmosphere and the lungs, as well as smelling. Gross impurities are removed by the fine nostril hairs, and finer impurities are enveloped in the mucous secretion of the intranasal lining and carried away by ciliary action. The air is warmed to a degree approaching body temperature and humidified. About 500 cc. of air are taken in during an ordinary inspiration, totaling 12,000,000 cc. daily.

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One-half ounce of any of the four Pablum® cereals (the usual daily feeding) supplies the infant with 4.3 mg. of elemental iron. This is 70% of the Recommended Daily Allowance for infants under 1 year. One ounce of Pablum supplies 141% of the R.D.A. for infants under 1 year and more than 100% of the Allowance for children up to 6 years.

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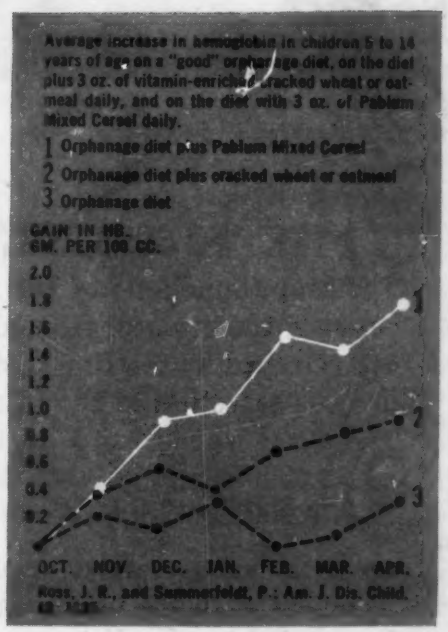
Average increase in hemoglobin in children 5 to 14 years of age on a "good" orphanage diet, on the diet plus 3 oz. of vitamin-enriched cracked wheat or oatmeal daily, and on the diet with 3 oz. of Pablum Mixed Cereal daily.
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1.4
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OCT. NOV. DEC. JAN. FEB. MAR. APR.
Ross, J. R., and Sammerfeldt, P.: Am. J. Dis. Child.

1. Smith, N. J., and Rosello, S.: J. Clin. Nutrition 1: 275, 1953;
2. Jeans, P. C., in A.M.A. Handbook of Nutrition, ed. 2, New York, Blakiston, 1951, p. 280.

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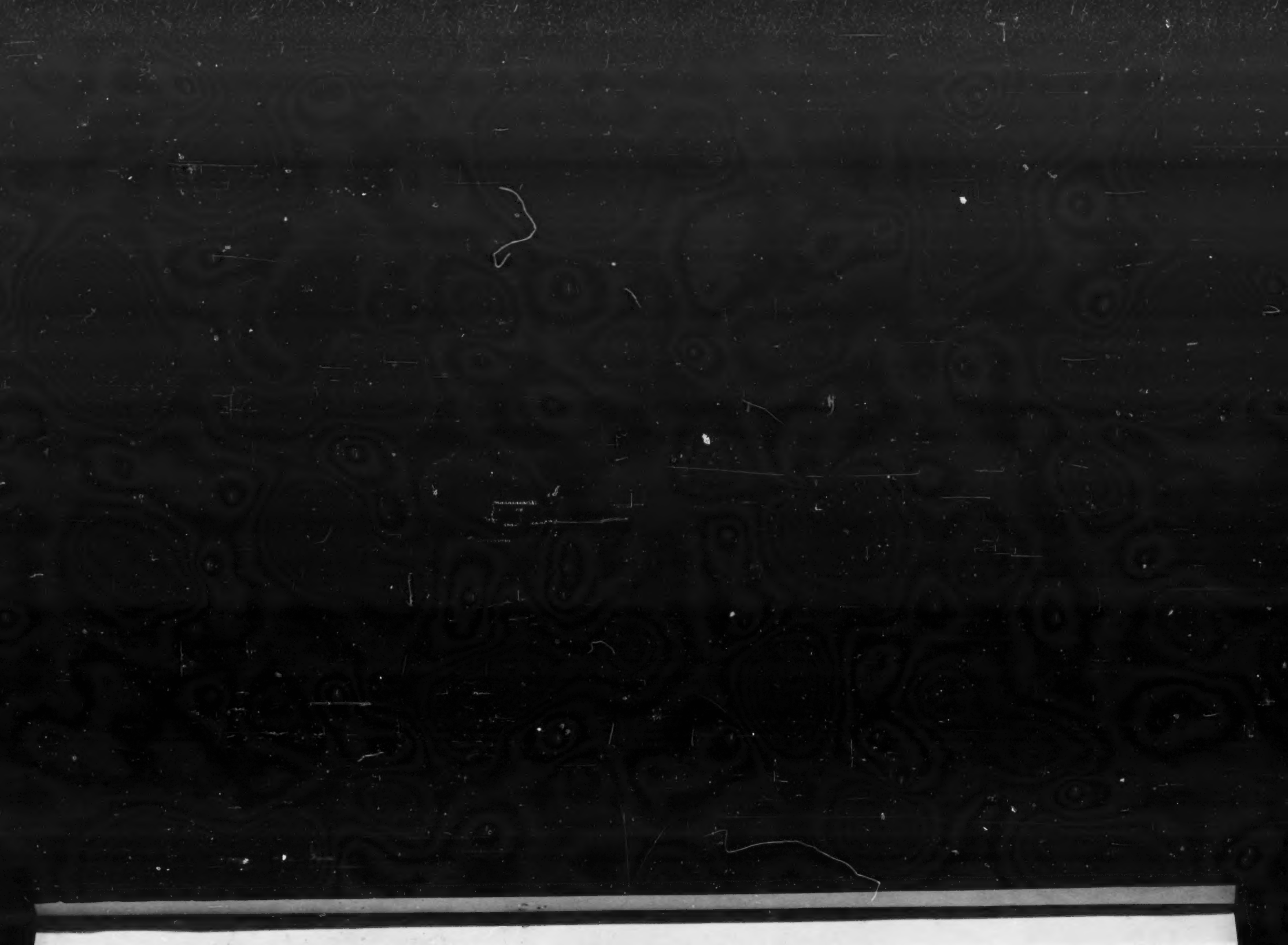
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